

USCIS Form I-693

Part 7. Vaccination Record

Disclaimer

I am not an attorney and my information should not be taken as legal advice.

St. Vincent Catholic Charities Immigration Law Clinic represents Immigrants and Refugees, and this information is meant to guide the Health Department to work in tandem with our office.

The information presented to you today has been compiled through research done on the USCIS and CDC websites.

Purpose

- To report results of medical examinations
- Form is required for most applicants filing for adjustment of status to become a lawful permanent resident (or “green card”)
- Certain results will make an applicant inadmissible to the United States for public health grounds
- All results are **confidential**
- **Editions:**
 - As of 07/27/15, the USCIS will longer accepts older versions of this form.
 - The form dated 03/30/15 is the only acceptable version.
 - If the applicant comes in with an older version, have them return to their attorney for a new form or have them print it out themselves.
 - In the future, you may check the validity of editions accepted at <http://www.uscis.gov/i-693>

Inadmissible Health- Related Grounds

See § 212(a)(1)(A) of the Immigration and Nationality Act (INA)

- U.S. Immigration law divides the health-related grounds of inadmissibility into the following four general categories:
 - a) Communicable diseases of public health significance
 - b) Lack of proof of having received required vaccinations**
 - c) Physical or mental disorders with associated harmful behavior or a history of associated harmful behavior, and
 - d) Drug abuse or addiction

General Instructions

- Truthfully and accurately report the results
- Fill out form in **black** ink, typed or handwritten
- Form should be filled out in **English only**
- The applicant should *only* fill out the identifying information at the top of each page and in **Part 1.**
 - All other parts will be filled out by a medical professional
- **Do not sign anything until the entire record is completed.**

For Refugee Adjustment Applicants ONLY

- The vaccination assessment is the only medical examination required for Refugees seeking adjustment of status (i.e. to receive a green card).
- Health Departments are considered a “civil surgeon” under the USCIS blanket definition.
- In this case, the medical professional must complete:
 - **Part 1.** – Confirm Identity of Applicant
 - **Part 4.** – Civil Surgeon’s Information
 - **Part 7.** – Vaccination Record

Completing Part 1.

1. Confirm the Identity of the Applicant in Part 1.



Report of Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2017

▶ **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, NOT the civil surgeon)

1. Name
Family Name (Last Name) Given Name (First Name) Middle Name

2. Home Address
Street Number and Name Apt. Ste. Flr. Number
City or Town State ZIP Code

3. Gender Male Female

4. Daytime Telephone Number

5. Mobile Telephone Number (if any)

6. Email Address (if any)

7. Date of Birth (mm/dd/yyyy)

8. City/Town/Village of Birth

9. Country of Birth

10. Alien Registration Number (A-Number) (if any)
▶ A-

*This may be blank if applicant has not yet received an A-number or cannot remember it.

Name should match form of identification.

#1-10 should be completely filled out.

Completing Part 1.

2. Have applicant read the “Applicant’s Certification” in **Part 1.**
 - Applicant must check either box #11 or #12
 - if #12 is checked, **Part 2.** must also be filled out
 - Have applicant sign and date the form under item #13, but only in the presence of the medical professional.
 - If applicant is 14 or older, he or she must sign for his or herself
 - if under 14, a parent or legal guardian may sign

Completing Part 1.

2. Have applicant read the "Applicant's Certification" in **Part 1**.

Applicant's Certification

I certify, under penalty of perjury, that I am the person who is identified in **Part 1** of this Form I-693, and that the information in **Part 1** of this benefit request is complete, true, and correct. I understand the purpose of this medical examination, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false or altered information or documents with regard to my medical examination, I understand that any immigration benefit I derived from this medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

NOTE: Select the box for either **Item Number 11. or 12.**

11. I can read and understand English, and have read and understand every question and instruction in **Part 1** of this Form I-693, as well as my answer to every question in **Part 1**. I have read and understand the above **Applicant's Certification**.
12. The interpreter named in **Part 2** has read to me every question and instruction in **Part 1** of this Form I-693, as well as my answer to every question in **Part 1**, in , a language in which I am fluent. I understand every question and instruction in **Part 1** of this Form I-693 as translated to me by my interpreter, and have provided complete, true, and correct responses in the language indicated above. The interpreter named in **Part 2** also has read the above **Applicant's Certification** to me, in a language in which I am fluent, and I understand the **Applicant's Certification** as read to me by my interpreter.

Check #11 or #12



Applicant's Signature

13. Signature - Do not sign or date Form I-693 until instructed to do so by the civil surgeon Date of Signature

John Michael Smith

(mm/dd/yyyy)

07/20/2015

Sign and date,
in your presence




Completing Part 1.

3. Complete Item #14 in **Part 1.** by noting the form of identification presented and filling out the A-Number (if any)
 - Compare this information with the information at the top of every page of the I-693
 - Verify that the name and identification number (if present) is correct on each page

Completing Part 1.

3. Complete Item #14 in **Part 1.** by noting the form of identification presented and filling out the A-Number (if any)

Compare to Information in #1-10



Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
Smith	John	Michael	▶ A- 2 3 4 5 6 4 8 9 3

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon) (continued)

14. To be completed by the civil surgeon:

- A. Form of applicant identification presented (for example, passport or driver's license)**

Driver's License

- B. Identification Number**

K 362 452 154 265



Fill out form of identification as best as you can.

Completing Part 2. – Interpreter's Contact Information, Certification and Signature

If the applicant selected box #12 (requiring the use of an interpreter) in **Part 1.**, **Part 2.** must also be filled out.

Part 2. Interpreter's Contact Information, Certification and Signature			
Provide the following information concerning the interpreter.			
Interpreter's Full Name			
1. Interpreter's Family Name (Last Name)	Interpreter's Given Name (First Name)		
Johnson	Sam		
2. Interpreter's Business or Organization Name (if any)			
Lansing Refugee Aid			
Interpreter's Mailing Address			
3. Street Number and Name	Apt.	Ste.	Flr. Number
123 Center St.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
City or Town	State	ZIP Code	
Lansing	MI	48910	
Province	Postal Code	Country	
		U. S. A.	
Interpreter's Contact Information			
4. Interpreter's Daytime Telephone Number	5. Interpreter's Email Address (if any)		
5179856632	johnsons@gmail.com		
Interpreter's Certification			
I certify that:			
I am fluent in English and <input type="text" value="French"/> , which is the same language provided in Part 1., Item Number 12. ;			
I have read to this applicant every question and instruction in Part 1. of this Form I-693, as well as the answer to every question in Part 1. , in the language provided in Part 1., Item Number 12. ; and			
I have read the Applicant's Certification to the applicant in the same language provided in Part 1., Item Number 12.			
The applicant has informed me that he or she understands every instruction and question in Part 1. of this Form I-693, as well as the answer to every question in Part 1. , and the applicant verified the accuracy of every answer; and			
The applicant also has informed me that he or she understands the Applicant's Certification.			

The interpreter certifies that he or she has read the **Applicant's Certification** to the applicant in a language in which he or she is fluent. If the interpreter feels uncomfortable testifying that the applicant *understands* the Applicant's Certification, that language may be crossed off before signed. The same is true if the interpreter feels uncomfortable stating that they read every instruction.

The interpreter must sign and date **Part 2.**

Part 2. Interpreter's Contact Information, Certification and Signature (continued)

Interpreter's Signature

6. Interpreter's Signature

Sam Johnson or *(phone interpreter used)*

Date of Signature

(mm/dd/yyyy)

07/20/2015

Completing
Part 2.

*If a phone service is used for interpretation, the Civil Surgeon must make a note in place of a signature.

Completing Part 4.

1. Fill out the Contact Information for the “Civil Surgeon”

Part 4. Civil Surgeon's Contact Information, Certification, and Signature (Do not sign Form I-693 and do not have the applicant sign in **Part 1**. until all health-related follow-up requirements are met.)

Civil Surgeon's Information

1. Family Name (Last Name) Given Name (First Name) Middle Name (if applicable)
2. Name of Medical Practice, Facility, or Health Department

Physical Address

3. Street Number and Name Apt. Ste. Flr. Number
City or Town State ZIP Code

Contact Information

4. Daytime Telephone Number
5. Email Address (if any)

Completing Part 4.

2. Read the “Civil Surgeon’s Certification”

Civil Surgeon's Certification

I certify under penalty of perjury under United States law that:

I am a civil surgeon designated to examine applicants seeking certain immigration benefits in the United States OR a physician who qualifies under a blanket designation specified by policy or law;

I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations, unless otherwise exempted;

I performed an examination of the person identified in **Part 1.** of this Form I-693, after having made every reasonable effort to verify that the person whom I examined is in fact the person identified in **Part 1.**;

I performed the examination in accordance with the Centers for Disease Control and Prevention's (CDC) *Technical Instructions*, as well as all supplemental information or updates; and

All the information I provided on this Form I-693 is complete, true, and correct - based on the information provided to me by the applicant.

Completing Part 4.

3. Sign and date under the Certification.
 - Must sign certification after form is **complete**
 - Fill out identifying information *before* applicant leaves
 - *Signature must be **original***
 - Exception: for Health Departments performing vaccinations for *refugee adjustment applicants only*, the original or stamped signature of the physician on staff must be present
 - USCIS will reject signatures by attending nurses, physician assistants, or other medical professionals who are not licensed physicians
 - Health Departments must also place either the official stamp or raised seal, whichever is customarily used, in **Part 4**.

Completing Part 4.

3. Sign and date under the Certification after all tests and other portions of the form have been completed.

Civil Surgeon's Signature

6. Civil Surgeon's Signature

Jason M. Franklin, M.D.

Date of Signature

(mm/dd/yyyy)

07/20/2015

(Health departments and military treatment facilities MUST place their official stamp or seal here)

(official stamp or seal here)



Completing Part 7. – Vaccination Record

Part 7. Vaccination Record (See *Technical Instructions* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html for list of required vaccines)

Please make sure to mark every row. Reserve all comments for the Remarks section below. **NOTE:** For purposes of the influenza vaccine, the flu season is October 1 through March 31. For applicants who only require a vaccination assessment: Submit only this page with **Part 1., Part 2.,** and **Part 4.** of Form I-693 (the applicant, regardless of what is required, may still need an interpreter). For more information, see Form I-693 Instructions, **Part 3. Frequently Asked Questions.**

Vaccine History Transferred From A Written Record					Vaccine Given	Complete Series	Blanket Waivers to be Requested from USCIS (Not Medically Appropriate)			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Not Age-Appropriate	Contraindication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT <input type="checkbox"/> DTaP <input type="checkbox"/> DTP <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: Td <input type="checkbox"/> Tdap <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: OPV <input type="checkbox"/> IPV <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hib							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NOTE: Give a copy to the applicant.

Results:

- Applicant may be eligible for blanket waivers as indicated above
- Applicant will request an individual waiver based on religious or moral convictions
- Vaccine history complete for each vaccine, all requirements met
- Applicant does not meet immunization requirements

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

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Remarks (if any):

Completing Part 7. – *Vaccination* *Record*

1. Determine the age of each applicant
2. Review each applicant's medical history and records.
 - Applicant will bring vaccination history with them to appointment
 - Vaccination history may also be on file with the Health Department
3. Determine the vaccines each applicant needs.
4. Assess contraindications and precautions.
 - the civil surgeon must screen the applicant for contraindications and discuss with the applicant any potential adverse reactions.
5. Assess each applicant's laboratory needs.
 - i.e. what vaccinations the applicant still requires

Completing Part 7. – *Vaccination* *Record*

- Acceptable vaccination documentation:
 - a personal vaccination record; or
 - a copy of a medical chart with entries made by a physician or other appropriate medical personnel;
 - or a report from MCIR
<http://www.mcir.org/publicrequestimmuniz.html>
- Records must include the dates of receipt (month, day, and year)
- Document must not appear to have been altered
- Dates of vaccinations should seem *reasonable*
- **Self-reported doses of vaccines without written documentation are not acceptable.**

Completing Part 7. – *Vaccination* *Record*

- If the applicant has never received a vaccine, or cannot prove they received it, the applicant may choose to either have the health department administer the vaccine, or they may see their family doctor.
- If the applicant chooses to see their family doctor, they must return to the original civil surgeon to note their completed vaccines.
 - The civil surgeon should not complete the form until the applicant has returned with the completed vaccines.

Completing Part 7. – Vaccination Record

Vaccine History Transferred From A Written Record					Vaccine Given	Complete Series	Blanket Waivers to be Requested from USCIS (Not Medically Appropriate)			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Not Age-Appropriate	Contra-indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT <input type="checkbox"/> DTaP <input type="checkbox"/> DTP <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: Td <input type="checkbox"/> Tdap <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: OPV <input type="checkbox"/> IPV <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hib							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vaccinations received previously (by ICHD or other medical professionals)

Vaccinations received from the civil surgeon completing the form

Completing Part 7. – *Vaccination* *Record*

- *Waivers* may be granted in certain instances if the Civil Surgeon determines the vaccination is not medically appropriate
- The U.S. Department of Health and Human Services has determined that a vaccination is “not medically appropriate” if:
 1. The vaccine is not recommended for the specific age group;
 2. There is a medical reason why it would not be safe to have the vaccine (e.g. previous allergic reactions);
 - For a description of contraindications and precautions to be considered, please visit:
<http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html>
 3. The applicant would be unable to complete the entire series of required vaccine within a reasonable amount of time;
 - Applicants are required to have received at least one dose of each recommended vaccine
 4. For the influenza vaccine, it is not the flu season.
 - Flu season is October 1 – March 31

Completing
Part 7. –
Vaccination
Record

Age-Appropriate Vaccines required for all applicants:

- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Rotavirus
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Meningococcal
- Varicella
- Pneumococcal
- Influenza

* For precise immunization schedules, refer to:

<http://www.cdc.gov/vaccines/schedules/index.html>

Completing Part 7. – *Vaccination* *Record*

Updates to Vaccination Requirements:

- Human papillomavirus vaccine and zoster vaccine are no longer required.
 - *Human papillomavirus vaccine* does not need to be given to **females 11 through 26 years** of age.
 - *Zoster vaccine* does not need to be given to persons **60 years** of age or older.
- Meningococcal conjugate vaccine, specifically tetravalent meningococcal conjugate vaccine (MCV₄), should be given to persons **11 through 18 years** of age.
 - *Meningococcal polysaccharide vaccine* (MPSV) or other forms of meningococcal conjugate vaccine (e.g., monovalent MCV) is not an acceptable alternative for this age group.
- Influenza vaccine is required for applicants **6 months through 18 years** of age during the influenza (flu) season.
 - Influenza vaccine continues to be required for adults **50 years** of age or older.

Check the appropriate box for each vaccine if it is determined that the vaccination is “not medically appropriate” for the applicant

- a. Not age-appropriate
- b. Contraindication (e.g. previous allergic reactions)
- c. Insufficient time interval
- d. Not flu season

Completing Part 7. – Vaccination Record

Vaccine History Transferred From A Written Record					Vaccine Given	Complete Series	Blanket Waivers to be Requested from USCIS (Not Medically Appropriate)			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VI" if varicella history	Not Age - Appropriate	Contra- indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT <input type="checkbox"/> DTaP <input type="checkbox"/> DTP <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: Td <input type="checkbox"/> Tdap <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: OPV <input type="checkbox"/> IPV <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hib							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Completing Part 7. – *Vaccination* *Record*

- A waiver may also be granted if the applicant objects to a required vaccination because of sincerely held religious beliefs or moral convictions.
- The applicant will inform the civil surgeon if this is the case, and it should be marked on the form before signed.

Completing Part 7. – Vaccination Record

Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NOTE: Give a copy to the applicant.

Results:

- Applicant may be eligible for blanket waivers as indicated above
- Applicant will request an individual waiver based on religious or moral convictions
- Vaccine history complete for each vaccine, all requirements met
- Applicant does not meet immunization requirements

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

FOR USCIS USE ONLY
Remarks (if any):

Check this box if a vaccine is deemed "not medically appropriate"

Check this box if the applicant objects due to a sincerely held religious belief or moral conviction

Completing Part 7. – Vaccination Record

NOTE: Give a copy to the applicant.

Results:

- Applicant may be eligible for blanket waivers as indicated above
- Applicant will request an individual waiver based on religious or moral convictions
- Vaccine history complete for each vaccine, all requirements met
- Applicant does not meet immunization requirements

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

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Remarks (if any):

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If a vaccine is deemed “not medically appropriate” due to contraindication or precaution, be sure to note what specific issue the applicant has with the vaccine in the “Remarks” section.

**But be sure not to write in this “Remarks” section.

Completing Part 7. – Vaccination Record

Completing the Results Section

Results:

- Applicant may be eligible for blanket waivers as indicated above
- Applicant will request an individual waiver based on religious or moral convictions
- Vaccine history complete for each vaccine, all requirements met
- Applicant does not meet immunization requirements

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

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Remarks (if any):

If the applicant has met the vaccination requirements, i.e., completed all required vaccines, this box must be checked.

* This box includes blanket waivers.

If the vaccine history is incomplete and the applicant refuses administration of a single dose of any required vaccine that is *medically appropriate* for the applicant, this box must be checked.

* This box includes individual waivers based on religious or moral convictions.

Completing Part 7. – *Vaccination* *Record*

Completing the vaccination series

- Place an “X” in the "Completed Series" box if the applicant has completed the vaccination series.
- If a lab test proves an applicant is fully immune, the month, date, and year of the test must be written in the "Completed Series" box.
- If a reliable written or oral history of varicella disease is given, "VH" must be written in the "Completed Series" box for varicella history.

Completing Part 7. – Vaccination Record

Completing the vaccination series

Vaccine History Transferred From A Written Record					Vaccine Given	Complete Series	Blanket Waivers to be Requested from USCIS (Not Medically Appropriate)			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Not Age - Appropriate	Contra- indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT <input type="checkbox"/> DTaP <input type="checkbox"/> DTP <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: Td <input type="checkbox"/> Tdap <input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: OPV <input type="checkbox"/> IPV <input type="checkbox"/>						VH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hib							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B					05/20/15	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A						Immune 05/20/15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Completing the I-693

- After **Part 1.**, **Part 2.**, **Part 4.** and **Part 7.** have been completed, the Civil Surgeon must sign and date **Part 4**, Item #6.
- Make two copies of the completed form
 - Retain one for your records
 - Give a copy to the applicant
 - Place the original in a sealed envelope
 1. On the front, write in capital letters: "DO NOT OPEN. FOR USCIS USE ONLY."
 2. Write the Applicant's full name on the front.
 3. On the back, write your initials across the seal where the flap meets the envelope.
 4. Seal the entire flap with clear tape. Make sure the tape covers your initials as well as the flap.
 5. Mail the sealed letter to:
STVCC – ILC
2800 W. Willow St.
Lansing, MI 48917

Additional Resources

- For specific technical instructions on vaccinations, visit <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html>
- Website for technical instructions on form is *not currently functioning*; instead, visit <http://www.cdc.gov/immigrantrefugeehealth/laws-regs/vaccination-immigration/revised-vaccination-immigration-faq.html> for more information on FAQs
- Detailed instructions for completing the form can be found on the USCIS website here: <http://www.uscis.gov/sites/default/files/files/form/i-693instr.pdf>
- For FAQs on vaccinations, visit <http://www.uscis.gov/news/questions-and-answers/vaccination-requirements>

Thank You

- Reminder, this information is not meant to take the place of legal advice.
- St. Vincent Catholic Charities represents Immigrants and Refugees.
- The purpose of this information is to help your office work in tandem with our clients and to inform your staff on the requirements of the I-693.
- Any legal advice sought should be directed toward ICHD attorneys.
- Thank you for your time.