

Using Immigration Physicals to Enhance Operating Margin

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Urgent care is a “volume-driven business”—meaning once recurring costs like salaries, rent, utilities, advertising and depreciation are covered, each incremental visit contributes directly to the bottom line. To increase volume and enhance the profitability of their centers, many urgent care operators turn to “ancillary services”—generally cash-only services administered by urgent care providers that leverage existing infrastructure but do not entail treating minor injury and illness.

For more information on common ancillary services in urgent care, see: [Boosting Revenue by Working Harder—or Smarter?, Journal of Urgent Care Medicine, February, 2008, pg. 29.](#)

A common ancillary service for urgent care providers is “Immigration Medicine”—documentation of physical exam, vaccinations, and lab tests required by the United States Citizen and Immigration Services (USCIS) for every non-U.S. citizen desiring a change in his/her immigration status.

In order to practice Immigration Medicine, a physician must have a “Civil Surgeon” designation, which according to www.uscis.gov entails locating the USCIS District Office serving the provider’s state and sending:

- A letter to the District Director requesting consideration
- A copy of a current medical license
- A current resume that shows four years of professional experience (excluding residency)
- Proof of U.S. citizenship or lawful status in the United States
- Two signature cards showing name typed and signature below

There is no separate form or application required. However, there are only a limited number of designated Civil Surgeons appointed to each area and new applicants will be turned away or waitlisted if there is already a sufficient supply of Civil Surgeons in their community. Once designated as a Civil Surgeon, a provider will be listed on the USCIS website and may begin offering Immigration Physicals to the general public.

Paperwork and Examination

The US Centers for Disease Control and Prevention (CDC) provides technical instructions for conducting the physical examination on its website at <http://www.cdc.gov/immigrantrfugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html>. Current USCIS vaccination requirements include:

- Mumps
- Measles
- Rubella
- Polio
- Tetanus and Diphtheria Toxoids
- Pertussis
- Haemophilus influenzae type B
- Hepatitis B
- Any other vaccine-preventable diseases recommended by the Advisory Committee for Immunization Practices

Although the actual physical exam is not particularly time consuming for the doctor, there is a lot of paperwork involved for the front office staff. Front office staff will need to be trained in this documentation—flow sheets or checklists (such the one provided in Appendix 1) can facilitate transactions and assure all documentation is complete.

Patients are required to bring several items to the physical:

- Patient Information Form
- Form I-693 (see Appendix 2)
 - Patient should complete Section 1 in advance of the appointment.
 - Clinics providing immigration physicals should also keep the forms on-site.
- Vaccination records, showing proof of vaccination, which includes:
 - Type of vaccination administered
 - Date administered
 - Physician who administered the vaccination
- Copies of previous test results, if applicable
 - HIV, Tuberculosis Skin Test or Chest X-Ray
- Photo identification

Once the front desk staff reviews all materials, it determines which immunizations and tests have been administered and which are needed. Necessary vaccinations are administered and a physical examination is conducted by the Civil Surgeon. The I-693 Form specifies different examination components dependent on the age of the patient. Laboratory tests may also be required as part of the examination requirements—samples are collected and sent out by the clinic staff and once results are received, they are documented by the physician on the I-693 Form.

The completed original I-693 Form, with the Civil Surgeon’s signature, is sealed in an envelope along with a copy of the patient’s photo ID and chest x-ray (if applicable) and provided to the patient to submit unopened to INS with his/her application for processing.

Revenue Opportunity of Immigration Physicals

Immigration Physicals constitute a cash-only business that entails assuring an applicant is current on all required vaccinations, conducting tests for HIV, Syphilis, and Tuberculosis, and providing a physical examination by an authorized Civil Surgeon. Fees come from processing the paperwork, conducting the physical exam, and administering necessary tests and immunizations.

USCIS does not have a set or recommended fee schedule for Immigration Physicals so pricing is up to the individual provider. Typically an urgent care center will charge a base fee of \$75 to \$150 for the physical and then charge a la carte for vaccinations, tests or x-rays administered resulting in a total visit charge of \$250 to 300 or more. To simplify pricing, some practices will offer an “all inclusive” immigration physical for \$400 to \$450 or more. *A sample Immigration Physical Charge Ticket is available to UCAOA Members on UConnect.* With moderate volume in a metropolitan area, immigration physicals can easily add \$100,000 or more to a center’s net collections.

When setting pricing, thought should be given that families tend to come for immigration physicals together. A married couple with two children could easily generate \$800 to \$1,200 in cash revenue in a single appointment. Applicants with USCIS also span the economic spectrum—from Ph.D. engineers to day laborers—so price elasticity may be determined by the applicant profile in your community. To capture business and keep word-of-mouth, pricing must be competitive relative to other Immigration Medicine providers in the community.

It’s also important to “hold firm” on pricing. Some cultures are accustomed to bartering and will attempt to “talk down” or engage other antics to secure a lower price—yielding price for just one patient may establish a reputation that a center’s pricing is negotiable and result in an expectation of discounts for all. Likewise, paperwork should never be released to a patient without payment in full. When Immigration Physicals are promoted as a “cash only” service—onus falls on the patient to seek reimbursement from an employer, insurance, or any other third party.

Marketing of Immigration Physicals

Because the duty to obtain an Immigration Physical falls on the applicant, those requiring the service will generally look to the USCIS website, inquire of their Congressman or local immigration office, or ask friends and family where to go. Although some urgent care providers will develop relationships with local immigration attorneys and advocacy groups, providing marketing materials for them to display or hand out, generally referrals are directed by word of mouth and some providers see fairly significant immigration physical volume without any paid marketing at all.

There may be operational factors, however, that determine how appealing a facility is to certain immigrant groups. For instance, does a facility have available both male and female Civil Surgeons? Some cultures prohibit a patient from seeing a provider of the opposite sex. Is the facility open on Sunday? Some religious groups hold Friday or Saturday as holy days. Is the staff bi-lingual or is a translator available? If there are large immigrant populations in your community, it may be useful to enlist the assistance of ethnic advocacy groups in providing translation services. And is the facility accessible to a bus line? In urban areas it's common that recent immigrants lack reliable transportation. Applicants have been known to drive three hours or longer to another metropolitan area if there is a provider who better meets their needs.

Because Immigration Physicals bring new patients to the urgent care center, they provide an opportunity to “educate” patients who are less familiar with the US medical system as to when to utilize urgent care for their family's personal injury and illness needs. Patients who are satisfied with their Immigration Physical experience should return to the center and tell friends and family to do likewise.

Walk-in vs. Scheduled Appointments

Although most urgent care centers treat illness and injury on a walk-in basis, they use scheduled appointments for immigration physicals. Typically, walk-in clinics see declines in visit flow during the mid- to late-afternoon, mid-week, and seasonally during weekend hours. The ability to direct immigration physicals to these timeslots can result in better utilization of fixed staff and facility investments without affecting overall wait times. A simple scheduling process using an appointment book typically available from office supply stores will facilitate this process at your front office.

The only limitation is that the times that may work best for the provider are less convenient to applicants—if the center chooses to perform Immigration Physicals during “peak urgent care times” (such as Saturday morning), it should consider adding additional front office staff and/or providers to avoid extending waits in the core urgent care business.

Conclusion

High fixed costs and third-party payer reimbursement in urgent care mean that after a “breakeven” volume of patient visits is attained, additional visits serve to enhance the center's operating margins. Ancillary services like Immigration Physicals have been embraced by many urgent care operators as a way to increase profitability through relatively high priced visits that incur no Accounts Receivable carrying costs. Key is to have providers who are engaged and willing to seek the Civil Surgeon designation, learn the requirements of an Immigration Physical examination, and provide a quality patient experience that will generate word of mouth referrals.

Appendix 1: Sample Process Flow and Quality Assurance Checklist for Immigration Physicals

Chart Creation: *Items to be assembled into the patient’s chart prior to consultation with the physician.*

- | | | | |
|-----|---------------------------------------|-----|--|
| ___ | Patient Information Sheet* | ___ | Copy of Previous Immunization Records |
| ___ | Medical Questionnaire* | ___ | Copy of Previous Test Results |
| ___ | Immunization Record (Top Section)* | ___ | Tuberculosis Skin Test (PPD)* or Proof < 90 days Old |
| ___ | Physical Form (Top Section)* | ___ | Results of Chest X-Ray if < 6 Months Old |
| ___ | Photo Identification | | |
| ___ | HIV Testing Consent Form** | | |
| ___ | Pregnancy Form – Females Over Age 15* | | |
| ___ | Consent for Vaccines* | | |

**Samples of forms are provided to UCAOA members through the UConnect portal.*

*** Each state provides a template for informed consent—download the appropriate form by visiting your State Department of Health website.*

Physician’s Examination: *Items to be completed in the chart after the physician’s physical examination.*

- | | | | |
|-----|----------------------------------|-----|---------------------------------------|
| ___ | Civil Surgeon Copy of I-693 Form | ___ | Copy of Tuberculosis Skin Test (PPD) |
| ___ | Copy of Immunization Record | ___ | Copy of Chest X-Ray (If Positive PPD) |
| ___ | Copy of Photo Identification | ___ | Bloodwork Results |

Patient’s Packet: *Items to be returned to the patient upon payment and discharge.*

- ___ Provider’s Cover Sheet Letter*
- ___ Copy of Immunization Record
- ___ Photo Identification
- ___ Copy of Tuberculosis Skin Test (PPD)
- ___ Copy of Chest X-Ray (If Positive PPD)
- ___ Copy of Bloodwork Results

NOTE: Patient does not receive the I-693 Form. This goes in the INS envelope.

INS Envelope: *Items to be sealed into the envelope patient returns to Immigration & Naturalization Service.*

- ___ 3 Remaining I-693 Form Copies
- ___ Original Immunization Record
- ___ Copy of Photo Identification
- ___ Copy of Chest X-Ray (If Positive PPD)

NOTE: Bloodwork results are not included in the INS envelope.

Appendix 2: Sample Form I-693: Report of Medical Examination and Vaccination Record

A writable PDF version is available for download at: [U.S. Citizenship and Immigrations Web Site](http://www.uscis.gov)

<p>OMB No. 1611-0031 Expires 10/30/11</p> <p>Department of Homeland Security U.S. Citizenship and Immigration Services</p> <p>I-693, Report of Medical Examination and Vaccination Record</p> <p>START HERE - Type or print in CAPITAL letters (Use black ink)</p> <p>Part 1. Information About You (The person requesting a medical examination or vaccination must complete this part)</p> <p>Family Name (Last Name) _____ Given Name (First Name) _____ Full Middle Name _____</p> <p>Home Address: Street Number and Name _____ Apt. Number _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>City _____ State _____ Zip Code _____ Phone # (Include Area Code) no dashes or () _____</p> <p>Date of Birth (mm/dd/yyyy) _____ Place of Birth (City/Town/Village) _____ County of Birth _____ A-Number (if any) _____ U.S. Social Security # (if any) _____</p> <p>Applicant's Certification I certify under penalty of perjury under United States law that I am the person who is identified in Part 1 of this Form I-693. Report of Medical Examination and Vaccination Record, and that the information in Part 1 of this form is true to the best of my knowledge. I understand the purpose of this medical exam and the procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false information or documents with regard to my medical exam, I understand that any immigration benefits I derived from this medical exam may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.</p> <p>Signature: _____ Date (mm/dd/yyyy) _____</p> <p>Part 2. Medical Examination (The civil surgeon completes this part)</p> <p>1. Examination</p> <p>Date of First Examination _____ Date(s) of Follow-up Examination(s) if Required: _____ Date of Exam _____ Date of Exam _____ Date of Exam _____</p> <p>Summary of Overall Findings: <input type="checkbox"/> No Class A or Class B Conditions <input type="checkbox"/> Class A Conditions (see 2 through F below) <input type="checkbox"/> Class B Conditions (see 2 through G below)</p> <p>2. Communicable Diseases of Public Health Significance</p> <p>A. Tuberculin Test (TST): An initial screening test, either a Tuberculin Skin Test (TST) or an Interferon Gamma Release Assay (IGRA) is required for all applicants 2 years of age and older, for children under 2 years of age, see Technical Instructions at http://dhs.gov/eis/dhs.gov/eis/imm/immigration-check/medical.</p> <p>1. Tuberculin Skin Test (TST): <input type="checkbox"/> Not administered (TST exception applies) Date TST Applied _____ Date TST Read _____ Size of Reaction (mm) _____ Result: <input type="checkbox"/> Negative (sum or less of induration) <input type="checkbox"/> Positive (\geq 5 mm, chest X-ray required)</p> <p>2. Interferon Gamma Release Assay (IGRA) (for acceptable IGRAs consult the Technical Instructions and any updates posted on CDC's Web site at http://www.cdc.gov/ncidod/dq/civil.htm): <input type="checkbox"/> Not administered (IGRA exception applies) Name of Test _____ Date Blood Sample Drawn _____</p> <p>Form I-693 (Rev. 02/25/10) Page 2</p>	<p>Part 2. Communicable Diseases of Public Health Significance (Cont'd)</p> <p>Initial: _____ Result: <input type="checkbox"/> Negative (including indeterminate, or borderline/equivocal) (see chest X-ray required) <input type="checkbox"/> Positive (chest X-ray required)</p> <p>Initial Screening Test Results and Chest X-Ray Determination: <input type="checkbox"/> Chest X-ray not required (medically cleared for TB for USCIS) <input type="checkbox"/> Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (e.g., HIV) <input type="checkbox"/> Chest X-ray required due to initial screening test results <input type="checkbox"/> Chest X-ray required due to TST or IGRA exception (The civil surgeon must clearly specify the TST or IGRA exception in the "Remarks" field below.)</p> <p>4. Chest X-Ray: Required based on TST or IGRA result, or if specific TST or IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (e.g., HIV). Attach a copy of X-ray report.</p> <p>Date Chest X-Ray Taken _____ Date Chest X-Ray Read _____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Describe results in remarks)</p> <p>TB Classification/Findings (check only if chest x-ray was performed): <input type="checkbox"/> No Class A or Class B TB <input type="checkbox"/> Class B1 Pulmonary TB <input type="checkbox"/> Class B2 Pulmonary TB <input type="checkbox"/> Class B, Other Chest Condition (see TB-7) <input type="checkbox"/> Class A Pulmonary TB Disease <input type="checkbox"/> Class B1 Extra Pulmonary TB <input type="checkbox"/> Class B, Latent TB Infection</p> <p>Remarks: (Include any signs or symptoms of TB, additional tests, and therapy given, with stop and start dates and any changes.)</p> <p>Form I-693 (Rev. 02/25/10) Page 2</p>																																																																																																																														
<p>Part 2. Medical Examination (Continued)</p> <p>B. Syphilis</p> <p><input type="checkbox"/> Serologic Test for Syphilis (Required for applicants 15 years and older)</p> <p>Date Screening Run _____ <input type="checkbox"/> Screening Nonreactive <input type="checkbox"/> Screening Reactive, Time 1: _____ If Reactive, Date Confirmation Run _____ <input type="checkbox"/> Confirmation Nonreactive <input type="checkbox"/> Confirmation Reactive</p> <p>Findings: <input type="checkbox"/> No Class A or Class B Syphilis <input type="checkbox"/> Syphilis, Class A (untreated) <input type="checkbox"/> Syphilis, Class B (with residual defect, and treated in the past year)</p> <p>Remarks: (Include any therapy given with doses and dates.)</p> <p>C. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance</p> <p>Findings: <input type="checkbox"/> No Class A/B Condition <input type="checkbox"/> Granuloma Inguinale, Class A <input type="checkbox"/> Lymphogranuloma Venereum, Class A <input type="checkbox"/> Chancroid, Class A <input type="checkbox"/> Gonorrhea, Class A <input type="checkbox"/> Human's Disease (Category, Infection), Class A <input type="checkbox"/> Human's Disease (Category, Infection), Class B</p> <p>Remarks: (Include any therapy given and any counseling or referrals.)</p> <p>3. Physical or Mental Disorders With Associated Harmful Behavior</p> <p><input type="checkbox"/> No Class A or B Physical or Mental Disorder <input type="checkbox"/> Physical/Mental Disorder, With Associated Harmful Behavior, Class A <input type="checkbox"/> Physical/Mental Disorder, Without Associated Harmful Behavior, Class B</p> <p>Remarks: (Include diagnosis, with likelihood of harmful behavior to recur, therapy given, and any counseling, or referrals.)</p> <p>4. Drug Abuse/Drug Addiction</p> <p><input type="checkbox"/> No Class A or B Drug Abuse/Addiction <input type="checkbox"/> Substance (Drug) Use, Listed in Section 202 of Controlled Substance Act, Class A <input type="checkbox"/> Substance (Drug) Use, Not Listed in Section 202 of Controlled Substance Act, But With Associated Harmful Behavior, Class A <input type="checkbox"/> Prior Substance (Drug) Use in Remission, Class B</p> <p>Remarks: (Include any therapy given, rehabilitation, counseling, or referrals.)</p> <p>Form I-693 (Rev. 02/25/10) Page 3</p>	<p>Part 2. Medical Examination (Continued)</p> <p>6. Vaccinations (See Technical Instructions at http://www.dhs.gov/eis/dhs.gov/eis/imm/immigration-check/medical for list of required vaccinations)</p> <table border="1"><thead><tr><th rowspan="2">Vaccine</th><th colspan="3">Vaccine History Transferred From a Written Record</th><th rowspan="2">Vaccine Given by Civil Surgeon</th><th rowspan="2">Completed Series</th><th colspan="2">Waiver(s) to Be Requested From USCIS</th></tr><tr><th>Date Received (mm/dd/yyyy)</th><th>Date Received (mm/dd/yyyy)</th><th>Date Received (mm/dd/yyyy)</th><th>Mark as X if completed, with date of last dose of booster or "TST" if tuberculin history</th><th>Not Medically Appropriate</th><th>Blanket</th></tr></thead><tbody><tr><td>Specify: DT</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Specify: DTP</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Specify: TD</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Specify: OPV</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Specify: IPV</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>MMR (Measles, Mumps, Rubella) or if measles or other combination of the vaccines are given, specify vaccine(s):</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>TB</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Hepatitis B</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Vaccines</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Pneumococcal</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Influenza</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Rotavirus</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Hepatitis A</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Meningococcal</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></tbody></table> <p>Give Copy to Applicant: <input type="checkbox"/> Applicant may be eligible for blanket waiver(s) as indicated above. <input type="checkbox"/> Applicant will require an individual waiver based on religious or moral convictions. <input type="checkbox"/> Vaccine history complete for each vaccine, all requirements met. <input type="checkbox"/> Applicant does not meet immunization requirements.</p> <p>Name of Applicant _____ A-Number (if any) _____</p> <p>Remarks: (If needed, provide any remarks; e.g., reason for contraindications)</p> <p>Form I-693 (Rev. 02/25/10) Page 4</p>	Vaccine	Vaccine History Transferred From a Written Record			Vaccine Given by Civil Surgeon	Completed Series	Waiver(s) to Be Requested From USCIS		Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Mark as X if completed, with date of last dose of booster or "TST" if tuberculin history	Not Medically Appropriate	Blanket	Specify: DT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: DTP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: TD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: OPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: IPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MMR (Measles, Mumps, Rubella) or if measles or other combination of the vaccines are given, specify vaccine(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaccines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																								
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																								
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																								
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																								
<p>Part 2. Medical Examination (Continued)</p> <p>6. List other medical conditions, Class B other (e.g., hypertension, diabetes)</p> <p>Part 3. Referral to Health Department Other Doctor/Facility (To be completed by civil surgeon, if referral was required and made)</p> <p>Type or Print Name of Doctor or Health Department Receiving Required Referral _____ Date of Referral (mm/dd/yyyy) _____</p> <p>Address: (Street Number and Name, City, State, and Zip Code) _____ Daytime Phone # (Include Area Code) no dashes or () _____</p> <p>Remarks: (Include same medical conditions and reasons for referral.)</p> <p>Part 4. To Be Completed by Physician or Health Department Performing Referral Evaluation</p> <p>The applicant identified on this form was referred to me by the civil surgeon named in Part 3 of this form. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I evaluated/treated is the person identified in Part 1.</p> <p>Type or Print Full Name of Evaluating Physician or Health Department _____ Signature _____</p> <p>Address: (Street Number and Name, City, State, and Zip Code) _____ Date (mm/dd/yyyy) _____</p> <p>Name of Medical Practice or Health Department _____ Daytime Phone # (Include Area Code) no dashes or () _____</p> <p>Remarks: (Attach a separate sheet of paper, if needed.)</p> <p>Form I-693 (Rev. 02/25/10) Page 5</p>	<p>Part 5. Civil Surgeon's Certification (Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met.)</p> <p>I certify under penalty of perjury under United States law that I am a civil surgeon in current status designated to examine applicants seeking certain immigration benefits in the United States; I have a currently valid and unrevoked license to practice medicine in the state where I am performing medical examinations; I performed this examination of the person identified in Part 1 of this Form I-693, after having made every reasonable effort to verify that person whom I examined is the person identified in Part 1; that I performed the examination in accordance with the Centers for Disease Control and Prevention's Technical Instructions, and all supplemental information or updates; and that all information provided by me on this form is true and correct to the best of my knowledge, and belief.</p> <p>Type or Print Full Name (First, Middle, Last) _____ Signature _____</p> <p>Address: (Street Number and Name, City, State, and Zip Code) _____ Date (mm/dd/yyyy) _____</p> <p>Name of Medical Practice or Health Department _____</p> <p>Daytime Phone # (Include Area Code) no dashes or () _____ E-Mail Address _____</p> <p>Part 6. Health Department Identifying Information (If completed by State or local health department on behalf of a refugee, place a stamp or seal where indicated.)</p> <p>Type or Print Name _____ (Place State or local health department stamp/initial below)</p> <p>Signature _____</p> <p>Date (mm/dd/yyyy) _____ Daytime Phone # (Include Area Code) no dashes or () _____</p> <p>Part 7. For USCIS Use Only (Not to be completed by the civil surgeon)</p> <p><input type="checkbox"/> 112(g)(2)(B) Blanket Waiver for Vaccination Granted</p> <p>Remarks: (if needed):</p> <p>Form I-693 (Rev. 02/25/10) Page 6</p>																																																																																																																														

