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 02/28/2019

► **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. Your Full Name

Family Name (Last Name) | Given Name (First Name) | Middle Name

2. Physical Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

3. Other Information

A. Sex ☐ Male ☐ Female

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

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
► **A-**

F. USCIS Online Account Number (if any)
►

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

3. Applicant's Mobile Telephone Number (if any)

4. Applicant's Email Address (if any)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

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

Applicant's Certification

I authorize the release of any information from any of my records that USCIS may need to determine my eligibility for the immigration benefit I seek.

I further authorize release of information contained in this form, in supporting documents, and in my USCIS records to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws.

I understand that USCIS may require me to appear for an appointment to take my biometrics (fingerprints, photograph, and/or signature) and, at that time, if I am required to provide biometrics, I will be required to sign an oath reaffirming that:

1) I reviewed and provided or authorized all of the information in my form;

2) I understood all of the information contained in, and submitted with, my form; and

3) All of this information was complete, true, and correct at the time of filing.

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 form 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.

Applicant's Signature

NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.

5. Applicant's Signature ➡ _____ Date of Signature (mm/dd/yyyy) _____

NOTE TO ALL APPLICANTS AND CIVIL SURGEONS: If you or the civil surgeon do not completely fill out this form according to the instructions USCIS may deny your immigration benefit.

Part 3. Interpreter's Contact Information, Certification, and Signature

Provide the following information about the interpreter.

Interpreter's Full Name

1. Interpreter's Family Name (Last Name) _____ Interpreter's Given Name (First Name) _____

2. Interpreter's Business or Organization Name (if any) _____

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 3. Interpreter's Contact Information, Certification, and Signature (continued)

Interpreter's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. ☐ ☐ ☐ Number

City or Town

State

ZIP Code

Province

Postal Code

Country

Interpreter's Contact Information

4. Interpreter's Daytime Telephone Number

5. Interpreter's Mobile Telephone Number (if any)

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____, which is the same language specified in **Part 2.**, **Item B.** in **Item Number 1.**, and I have read to this applicant in the identified language every question and instruction on this form and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the form, including the **Applicant's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Parts 4. - 9. of this form must be completed by the civil surgeon.

Part 4. Applicant's Identification Information (To be completed by the civil surgeon)

Please complete the following about the applicant:

1. Form of identification presented by applicant (for example, passport or driver's license)

2. Document Identification Number

Foster City Medical Center

Primary Care and Urgent Care

PATIENT REGISTRATION FORM

please print in blue or black ink

Today's Date:			**Doctor/PCP:**	
Patient's Last Name:	**First:**	**Middle:**	Marital Status: Single / Married / Divorced / Separated / Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	**Birthdate: (MM/DD/YY)** / /	**Age:**
E-Mail Address:				**Sex:** ❑ M ❑ F
Street Address/P.O. Box:	**City:**		**State:**	**ZIP Code:**
Occupation:	**Home Phone Number:** ( )		**Cell Phone Number:** ( )	
Primary Language:	**Social Security Number:** - -		☐ ok to leave private messages on cell phone voice mail (e.g. test results, etc.)	

How did you hear about Foster City Medical Center?

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yelp ❑ Postcard/Letter ❑ Insurance ❑ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relation:	Phone Number: ( )

FINANCIAL AND OFFICE POLICIES

Communication: By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number(s) is not a condition of receiving our services.

Release of Medical Records: I authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. Additionally, I hereby authorize FCMC to release any or all medical records to other medical providers requesting such only when related to the coordination of my care.

Sharing information: If none of the following boxes are checked, you permit us to share your health information with adults who live at your address.

☐ information should not be shared with any other person, even those who live at my address

☐ information may be shared with the following person(s): _____

Consent to Treat: I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, or surgical care, x-rays, tests, medications, laboratory tests, or other services, which may be ordered by the physician participating in my care.

I understand coverage and cost of lab or other diagnostic tests ordered during office visits and annual preventive exam is subject to my insurance plan. For detailed benefit explanation, I could consult my insurance company before the tests are done. I understand that any balance unpaid by insurance will be billed to me and if this balance is not paid within two months, there will be a $20.00 charge added and it could be sent to collections.

❑I, the undersigned, acknowledge that the information I have provided above is accurate to the best of my knowledge. I have read and understood the above mentioned policies.

_____ _____

Patient/Responsible Party/Guardian Signature ***Date***

Foster City Medical Center

Primary Care and Urgent Care

PATIENT CONSENT FORM (HIPAA)

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

1. Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician certification.

You have the right to review a NOTE OF PRIVACY PRACTICES prior to signing this consent. Foster City Medical Center has the right to change its Notice of Privacy Practices from time to time and that you may contact FCMC at anytime to obtain a copy of the Notice of Privacy Practices.
You may revoke this consent in writing at anytime.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date:_____

Agreement for Immigration Physical Exams

+H4OG2o

By signing this document, I the Undersigned agree that:

- I have come to Foster City Medical Center to see a Civil Surgeon as part of my adjustment of status ("immigration exam")
- the service being provided is that the Civil Surgeon will take the time to: a) review my records, b) determine what steps would be necessary to complete the part of the immigration process that is the responsibility of the Civil Surgeon, and c) carry out or facilitate the carrying out of these steps, where it is within the Civil Surgeon's ability.
- the Civil Surgeon should be able to provide the following, barring unforeseen circumstances:
    - review of medical records, including immunizations, which are in English
    - physical examinations
    - carry out a TB skin test (administering, and checking result)
    - determining which additional vaccinations would fulfill requirements; arranging to have these vaccines administered (possibly at a different facility); in any case, the cost of vaccines and administration are not included within the base price.
    - ordering Xrays, blood tests and other tests, so that I can have them carried out at a lab/Xray clinic. The cost of these tests is not included within the base price (except for the TB skin test, which is included with the base price).
- if certain parts of this service are not necessary, not applicable, or otherwise cannot be done, the remainder of the service still constitutes the service being provided. The service does not include diagnosis or treatment of medical conditions, medical preventive health, or paperwork beyond what is necessary for immigration.
- results, such as skin test results, are interpreted by Civil Surgeon and assigned qualified medical staff, and are not to be influenced by interpretation by patient or other persons
- I have read the page entitled "What To Expect For My Immigration Medical Examination"
- either I am not a patient of the Kaiser Permanente health system, or I have read and understand the page entitled "Kaiser Permanente and Your Immigration Examination".
- payment in cash (or any other acceptable form) is for the service above, and is due prior to the service being provided. Since part of the service is the time spent to review the records and make the necessary decisions, no refund is possible once payment has been made, whether or not it is possible to carry out all parts of the service, and whether or not I am able to fulfill all the requirements necessary for adjustment of immigrant status.
- I understand that this service is administrative, not related to health care, and not covered by insurance. I agree not to submit a claim to medical insurance for reimbursement of this service, as it would be fraudulent to claim that this is a covered health care service.
- Civil Surgeon cannot/will not guarantee that, after reviewing records and/or test results, I will fulfill requirements for immigration, and any such guarantee is not part of the service
- this agreement constitutes the entire agreement between the Civil Surgeon and myself, and replaces any prior agreement, whether written or oral

Civil Surgeon:
Dr. Ka Wai Tam, M.D.
Civil Surgeon ID# 106577

x_____
(signed by immigration applicant)

_____ _____
(date) (name of immigration applicant)

❑ - check here if form not signed by applicant; write relationship of signer to applicant here:

What To Bring

- bring government-issued photo identification
- bring vaccination records
- any documents without English will need an official translation from a licensed translator
    - this includes Chinese and French. Dr.Tam reads Chinese and French but for official records we still need the translation.
- bring payment (cash or credit card only)
    - note that our price does not include vaccinations
    - payment for tests (blood, X-ray, etc.) is made to the lab or X-ray clinic, not to us.
- for non-English speakers, an interpreter must be present, and needs to sign the immigration form. The interpreter can be a friend/family member, or a professional interpreter. Our clinic staff will not sign your immigration form as an interpreter.
- bring any lab results you have; however, we may need to repeat lab tests for immigration purposes
- bring any medicine that you are taking (paper prescriptions, and LABELED pill bottles; unlabeled pills will be ignored)
    - this includes medicine not prescribed by a doctor
    - this includes medicine not taken by mouth (inhalers, creams, injections, etc.)
- other medical records are not required, but will help

What Will Happen

- be prepared for 90-minute visit, although usually it does not take that long
- a male or female genital exam usually needs to be done; for female patient examinations by a male doctor, a female nurse willl be present
- usually you need to come more than once, e.g. if a TB skin test is needed, or we need to do lab tests
- generally, you will need a TB skin test - you need to come back in 48-72h (2-3 days) after you have the skin test injection. Choose your appointment dates so that they are 2-3 days apart.
- most people, including children, will need to do a chest Xray, if the TB results are positive or equivocal. Be prepared that if you do not do the Xray, immigration might not accept your application.
- for tests that we are required to order by USCIS (such as the test for syphilis), we cannot use previous results, no matter how recent.
- typical vaccination requirements for adults include TdaP and influenza (“flu”) vaccine, and possibly hepatitis A & B, meningococcal, etc. Other required vaccines, which are usually already given in childhood, include: MMR, varicella, etc.
- note that what matters is not whether you have actually had the vaccines, but whether you have records to prove this. If records are not available, we may be able to do blood tests to check for some of the vaccinations, but other vaccines may need to be re-administered (medically this is usually not a problem to repeat vaccines).
- we cannot guarantee that you will fulfill requirements for immigration. However, if you do have a health problem preventing you from doing this, we may be able to arrange treatment to help you eventually fulfill the requirements.

(These instructions were updated 04/26/17)

Kaiser Permanente and Your Immigration Examination

If you do not have medical insurance, or your medical insurance is something other than Kaiser (e.g. Aetna, Anthem, Blue Cross, Blue Shield, Cigna, HealthNet, UnitedHealth, etc.), then this section does NOT apply to you.

In the past, immigration applicants who have Kaiser Permanente medical insurance ("Kaiser") have had trouble using Kaiser with their immigration examination. Be prepared you MIGHT NOT be able to fulfill requirements via the Kaiser system; in the past, Kaiser has at times not been able to:

- issue correct documentation showing proof that a patient has received a vaccination, instead stating only that the patient "should get" or "agreed to get" or "paid for" the vaccination
- correctly fax us lab results, instead insisting that they give paper copies to the patient only
- verify in writing that the patient's identity was verified with government-issued photo ID

We cannot accept Kaiser "secure email" documents as a way to get medical records such as lab results or vaccination records. We have tried in the past, but the secure email (really a link to a web site) would not work, on multiple browsers, multiple computers and multiple network providers.

If a CD-ROM is submitted, then for each required piece of information (e.g. varicella result, measles result, etc.) you must specify in writing where on the CD-ROM it is found: the name of the PDF file, and the page number of the PDF file. (In the past, we have had to pore-through files of over thirty pages to extract the relevant information.) We will ignore any file that is not a PDF file. We do not accept Xray images in lieu of Xray report by a certified radiologist who interprets the Xray images.

If this helps: Patients have had more luck contacting their Kaiser doctor directly, rather than going through general Kaiser staff.

By choosing to undertake your immigration examination with us, you confirm your understanding that reliance on Kaiser records to fulfill your immigration requirements may possibly result in failure to complete your medical examination. (However, Kaiser patients may still reasonably expect to be able to complete the immigration examination by not using the Kaiser system to complete the process.)

Foster City Medical Center

Tuberculosis Testing for Immigration Applicants

- tuberculosis (TB) testing consists of: (*first*) a screening test, and (*second*) possibly a chest Xray
- any applicant age 2 or above must have TB testing, including pregnant women (and sometimes children younger than 2). USCIS will not grant your immigration application without TB testing.
- the screening test can be either a **TB skin test** (price already included in our clinic immigration services) or a **TB blood test** (the lab will charge you about $300+)
- if the screening test result is positive (abnormal), you will need the Xray
- prior TB vaccination (BCG) does not affect what USCIS considers a normal or abnormal result
- you may choose to skip the screening test and just do the Xray, if you have documentation showing a previous positive (abnormal) screening test result
- you may ***not*** skip the TB testing just because a test done elsewhere was normal, says USCIS

Choice of screening test:

	Choice #1	Choice #2	Choice #3
Screening test	**TB skin test** - done at clinic (included with cost of visit) - few drops of fluid injected in skin - must return to clinic in 48-72 hours (clinic not open on Sundays) - ok even for pregnant women - ***not*** ok if previously treated for TB with a course of isoniazid (INH)	**TB blood test** - done at lab (lab will charge about $300+; might not be available at certain lab hours, e.g. available afternoons only) - can be done with other required blood tests (same blood draw) - no need for return visit - ok for pregnant women, and for those previously treated for TB	**skip the test** - if there is documentation of previous positive (abnormal) screening test result, ok to skip screening test this time
need Xray?	for normal result, no Xray needed	for normal result, no Xray needed	must have Xray

- Xray is required for an abnormal screening result, including for children and pregnant women. (USCIS states that pregnant women may wait till after giving birth, but this simply delays your immigration application.)
- results may show that you have TB ("active"), or "latent TB" (potential future TB), or neither (normal)

Latent TB: abnormal skin/blood test, but normal Xray, no symptoms (you feel fine)
Active TB: abnormal Xray; skin/blood test doesn't matter; symptoms don't matter (you might feel fine)

If you have **Latent TB**, then:
- your body contains the TB germs, but your immune system is suppressing it, so FOR NOW it is the same as having no infection at all.
- it does NOT mean that you have what people usually call an infection
- you are NOT contagious and are NOT considered a carrier. Your have normal Xrays.
- however ... with your latent TB infection, it MIGHT (or might not) reactivate into an **active TB** infection at any time in your life. It might be next month, or ten years from now, or never.
- it is OK to proceed with your immigration application, even if you don't treat your latent TB.

If you have **Active TB**, then:
- you might have a cough (with or without blood), or you might feel normal.
- you are contagious, even if you feel normal. You could be an active TB carrier, and infect all the people around you without realizing.
- you need immediate treatment and quarantine, and the Department of Health is notified.

Name:
_____ (write clearly)

Yes	No	**Please answer the following questions**
☐	☐	I have copies of a previous abnormal TB screening result, and at the same time I also wish to skip the TB screening test and proceed directly to the Xray.

(If "Yes", skip other questions; sign at bottom; give copy of previous positive result to staff.)

☐	☐	Do you choose the blood test *($300+ at the lab)* instead of the skin test *(no fee)*? (yes = blood test ; no = skin test) *If you have ever been previously treated for TB infection with at least 1 month of medicine, we will **not** administer the skin test.*
☐	☐	Have you been in any of the following ***Countries of High TB Burden*** within the past 5 years (even if just for a few hours to change airplanes)? If yes, which? (circle)

Angola	Mozambique
Bangladesh	Myanmar (Burma)
Brazil	Namibia
Cambodia	Nigeria
Central African Republic	Pakistan
China	Papua New Guinea
Congo, Republic of	Philippines
Congo, Democratic Republic of	Russian Federation ("Russia")
Ethiopia	Sierra Leone
India	South Africa
Indonesia	Tanzania
Kenya	Thailand
Korea, North (DPRK)	Vietnam
Lesotho	Zambia
Liberia	Zimbabwe

☐	☐	Do you understand that measurement of TB skin test reaction is to be performed by designated clinic staff only, and may or may not coincide with your own measurement? (If you do not need the skin test, you may skip this question.)
☐	☐	Do you understand that the USCIS specifies what result is considered normal or abnormal, and our clinic cannot change this? (The USCIS criteria are stricter. E.g. for a 5mm result, usually considered normal, USCIS requires an Xray.)
☐	☐	Do you understand that we cannot accept TB tests that we did not order?
☐	☐	Do you understand that the USCIS specifies what is considered latent TB, and that this is reported on the immigration forms (as a "Class B" condition)?
☐	☐	Do you understand that you may feel normal, have a normal Xray result, and still have latent TB?
☐	☐	Do you understand that, even if you have latent TB and even if you choose not to have treatment, it is OK to proceed with your immigration application?

.

Signature/Date: _____

(Form updated 2017-04-26)

Immigrant Status Applicant Health Questions

Name:

(form updated 2017-06-30)

Have you ever had any of the following for any reason? Today's date:

overall health issues? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ stayed overnight in hospital/institution for *any* reason
- ❑ needed a lot more caregiver attention than others my age
- ❑ for most of the past month I have had an unexplained problem

limb/joint problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ back/neck pain, or limb injury
- ❑ swollen joints

breathing problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ wheezing (e.g. when exercising)
- ❑ coughing
- ❑ want to quit smoking

skin problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ rash
- ❑ open wound now, or had one lasting a month or more

heart problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ high blood pressure or irregular heartbeat
- ❑ previous known heart/blood vessel disease

nerve/brain problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ had fainting / loss of consciousness
- ❑ had pain for which I needed pain medicine at least 10 times
- ❑ numbness/decreased sensation in any part of the skin

eye/ear problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ repeated eye/ear infections
- ❑ wear lenses ❑ pain

urination problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ pain on urination, or genital discharge
- ❑ kidney stones

infection problems? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ had infection lasting more than 3 weeks
- ❑ had sexually transmitted disease, including (but not limited to) syphilis, gonorrhea, granuloma inguinale, chancroid, lymphogranuloma venereum
- ❑ had infection where I was asked to isolate myself, including (but not limited to) active tuberculosis, Hansen's disease (leprosy), etc.

mood/behavioral factors? ❑ None related to this category ❑ other *(write explanation here)*
- ❑ I have smoked within the past 3 years *(write how much)*
- ❑ I have had alcohol within the past 3 years *(write how much)*
- ❑ prior use of marijuana / other addictive substance
- ❑ gambling or other addictions

Is any of the following true? *(may affect vaccination requirements)* ❑ none of these are true
- I have an immune condition (e.g. HIV, transplant patient, spleen problem) ❑ one or more of these are true *(explain)*
- I am a man who has had sex with other men
- I have heart or lung or liver or kidney disease
- I have diabetes or high blood pressure
- I am pregnant
- I have had an alcohol problem

anything other significant history? ❑ Nothing else ❑ other *(write explanation here)*
- ❑ stayed in institution, for long-term physical/mental condition
- ❑ had surgery before (including minor procedures)
- ❑ I have committed/been accused of a crime (does not necessarily disqualify)
- ❑ at least once a month, I take medication (including herbals, supplements, other non-prescription medicine; creams/ eye-drops/ other non-oral; tobacco, alcohol, marijuana, etc.). List below; use the back of this page, or another paper, if needed.

❑ signed by someone other than applicant *(write relationship here)*

Sign here: Date:

Immigrant Status Applicant Vaccination Questions

Name:

(form updated 2017-06-30)

- all dates should be written in the format of: month / day / year
- if a vaccination was given fewer than 5 times, or not at all, leave the unused boxes blank
- vaccinations without records are considered by USCIS as equivalent to not having been vaccinated
- records must show the patient's name and date of vaccination administered, and not simply that the patient was due for a vaccine, or consented to have a vaccination. Receipts of payment alone do not constitute proof of vaccination.
- records not in English need an official translation for our clinic records
- for some missing vaccinations, it may or may not be possible to order a blood test to show that vaccination is not needed
- not all vaccinations are required to pass the immigration physical exam.
- this form does not have to be completed before seeing the Civil Surgeon for the physical examination, but does have to be completed before we can finish processing your paperwork

❑ I do not have records of any prior vaccinations
❑ I have records showing the dates of the following vaccinations

❑ I have taken medicine for tuberculosis (TB) for more than a month because of an abnormal TB test result (skin test, blood test or Xray) and/or because I actually had TB

Name of Vaccine	Date of 1st vaccination	Date of 2nd vaccination	Date of 3rd vaccination	Date of 4th vaccination	Date of 5th vaccination
Tetanus / Diphtheria / Pertussis					
Chickenpox / Varicella ❑ I have brought medical records proving previous infection					
Measles					
Mumps ❑ same dates as measles (leave this row blank)					
Rubella ❑ same dates as measles (leave this row blank)					
Influenza virus *(only most recent date needed)*					
Applicants aged 19-64 years only need to complete the lines above. Other applicants please also complete the following lines below.					
Rotavirus					
Haemophilus influenzae b ("Hib", *not* flu virus)					
Hepatitis A					
Hepatitis B					
Meningitis					
Polio					
Pneumonia					

_____

(signature/date)