

# I-693, Medical Examination of Aliens Seeking Adjustment of Status

(Please type or print clearly in black ink.)

**I certify that on the date shown I examined:**

1. Name (Last Name in CAPS)

(First Name)

(Middle Name)

2. Address (Street Number and Name)

(Apt. Number)

(City)

(State)

(Zip Code)

3. File Number (A Number)

4. Gender

Male

Female

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

6. Country of Birth

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

**General Physical Examination: I examined specifically for evidence of the conditions listed below. My examination revealed:**

No apparent defect, disease, or disability.

The conditions listed below were found (check all boxes that apply).

**Class A Conditions**

Chancroid

Hansen's disease, infectious

Mental defect

Psychopathic personality

Chronic alcoholism

HIV infection

Mental retardation

Sexual deviation

Gonorrhea

Insanity

Narcotic drug addiction

Syphilis, infectious

Granuloma inguinale

Lymphogranuloma venereum

Previous occurrence of one or more attacks of insanity

Tuberculosis, active

**Class B Conditions**

Hansen's disease, not infectious

Tuberculosis, not active

Other physical defect, disease or disability (specify below).

**Examination for Tuberculosis - Tuberculin Skin Test**

Reaction \_\_\_\_\_mm

No reaction

Not Done

Doctor's name (please print)

Date read

**Examination for Tuberculosis - Chest X-Ray Report**

Abnormal

Normal

Not done

Doctor's name (please print)

Date read

**Serologic Test for Syphilis**

Reactive Titer (confirmatory test performed)

Nonreactive

Test Type

Doctor's name (please print)

Date read

**Serologic Test for HIV Antibody**

Positive (confirmed by Western blot)

Negative

Test Type

Doctor's name (please print)

Date read

**Immunization Determination (DTP, OPV, MMR, Td-Refer to *PHS Guidelines* for recommendations.)**

Applicant is current for recommended age-specific immunizations.

Applicant is not current for recommended age-specific immunizations and I have encouraged that appropriate immunizations be obtained.

**REMARKS:**

**Civil Surgeon Referral for Follow-up of Medical Condition**

The alien named above has applied for adjustment of status. A medical examination conducted by me identified the conditions above which require resolution before medical clearance is granted or for which the alien may seek medical advice. Please provide follow-up services or refer the alien to an appropriate health care provider. The actions necessary for medical clearance are detailed on the reverse of this form.

**Follow-up Information:**

The alien named above has complied with the recommended health follow-up.

Doctor's name and address (please type or print clearly)

Doctor's signature

Date

**Application Certification**

I certify that I understand the purpose of the medical examination, I authorize the required tests to be completed, and the information on this form refers to me.

Signature

Date

**Civil Surgeon Certification:**

My examination showed the applicant to have met the medical examination and health follow-up requirements for adjustment of status.

Doctor's name address (please type or print clearly) MDICARE

Doctor's signature

Date

