

SUPPLEMENTAL FORM TO I-693
Adjustment of Status Applicant's Determination of Immunizations
To be completed by civil surgeon only

1. Applicant Identifying Information

_____ Date of Birth _____
 (Family) (Personal) (Middle) (Month, Day, Year)
 _____ Male _____ Female Passport # _____ Country _____

2. Immunization Record

Vaccine History Transferred from a Written Record					Vaccine Given	Completed series or Fully immune (Check if YES or write date of lab test if immune)	Waiver(s) to be Requested from INS			
Blanket										
Not Medically Appropriate							Not appropriate age	Contra-indication	Insufficient time interval	Not fall (flu) season
Vaccine	Date Rec'd Mo/Day/Yr	Date Rec'd Mo/Day/Yr	Date Rec'd Mo/Day/Yr	Date Rec'd Mo/Day/Yr	Date given by civil Surgeon Mo/Day/Yr					
DT/DTP										////////
Td										////////
Polio (OPV/IPV)										////////
Measles (or MR or MMR)										////////
Mumps (or MMR)										////////
Rubella (or MR or MMR)										////////
Hib										////////
Hepatitis B										////////
Varicella										////////
Pneumococcal										////////
Influenza										

3. Results

- Applicant may be eligible for blanket waiver(s) 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.

4. Civil Surgeon's Identifying Information

Civil Surgeon's Name _____ Date _____

Civil Surgeon's Signature _____