



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birthdate: (MM/DD/YY) / /	Age:
E-Mail Address:				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address/P.O. Box:		City:	State:	ZIP Code:
Occupation:		Home Phone Number: ()	Cell Phone Number: ()	
Primary Language:		Social Security Number: - -	<input type="checkbox"/> ok to leave private messages on cell phone voice mail (e.g. test results, etc.)	
How did you hear about Foster City Medical Center? <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yelp <input type="checkbox"/> Postcard/Letter <input type="checkbox"/> Insurance <input type="checkbox"/> 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. <input type="checkbox"/> information should not be shared with any other person, even those who live at my address <input type="checkbox"/> 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.				
<input type="checkbox"/> 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

+I9SB8x

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
 - 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.
- 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.
- 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 Expect For My Immigration Medical Examination

What To Bring

- bring government-issued photo identification, valid and not expired, which:
 - has your name exactly as it appears on your application
 - has the same signature that you will sign on the form. (E.g., if you signed your passport in a foreign language, then you must sign with the same foreign language signature.)
- 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 or tests
 - payment for tests (blood, X-ray, etc.) is made to the lab or X-ray clinic, not to us, with the exception of a possible optional cash discount on TB blood testing.
- 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, though we may still need to repeat the same lab tests
- 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
- although usually not needed, it is possible that a male or female genital exam needs to be done; for female patient examinations by a male doctor, a female nurse will be present
- some people may need to come more than once, though we will try to avoid this
- generally, you will need a TB blood test. The test can be done only in the afternoon (1-4pm) at the lab in our building. However, your immigration visit can be at any time of day, since you do not have to do the lab testing at the same time as your immigration visit; it does not even have to be on the same day.
- most people, including children and pregnant women, will need to do a chest Xray, if the TB results are positive (abnormal). 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 10/08/18)

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.)

Immigrant Status Applicant Health Questions

Name: _____

(form updated 2018-10-02)

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

overall health issues? <input type="checkbox"/> stayed overnight in hospital/institution for <i>any</i> reason <input type="checkbox"/> needed a lot more caregiver attention than others my age <input type="checkbox"/> for most of the past month I have had an unexplained problem	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
limb/joint problems? <input type="checkbox"/> back/neck pain, or limb injury <input type="checkbox"/> swollen joints	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
breathing problems? <input type="checkbox"/> wheezing (e.g. when exercising) <input type="checkbox"/> coughing for over a week <input type="checkbox"/> want to quit smoking	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
skin problems? <input type="checkbox"/> rash <input type="checkbox"/> open wound now, or had one lasting a month or more	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
heart problems? <input type="checkbox"/> high blood pressure or irregular heartbeat <input type="checkbox"/> previous known heart/blood vessel disease	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
nerve/brain problems? <input type="checkbox"/> had fainting / loss of consciousness <input type="checkbox"/> had pain for which I needed pain medicine at least 10 times <input type="checkbox"/> numbness/decreased sensation in any part of the skin	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
eye/ear problems? <input type="checkbox"/> repeated eye/ear infections <input type="checkbox"/> wear lenses <input type="checkbox"/> pain	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
urination problems? <input type="checkbox"/> pain on urination, or genital discharge <input type="checkbox"/> kidney stones	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
infection problems? <input type="checkbox"/> had infection lasting more than 3 weeks <input type="checkbox"/> had sexually transmitted disease, including (but not limited to) syphilis, gonorrhea, granuloma inguinale, chancroid, lymphogranuloma venereum <input type="checkbox"/> had infection where I was asked to isolate myself, including (but not limited to) active tuberculosis, Hansen's disease (leprosy), etc. <input type="checkbox"/> was in the same place as someone who had tuberculosis (TB)	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
mood/behavioral factors? <input type="checkbox"/> I have smoked within the past 3 years (<i>write how much</i>) <input type="checkbox"/> I have had alcohol within the past 3 years (<i>write how much</i>) <input type="checkbox"/> prior use of marijuana / other addictive substance <input type="checkbox"/> gambling or other addictions	<input type="checkbox"/> None related to this category	<input type="checkbox"/> other (<i>write explanation here</i>)
Is any of the following true? (<i>may affect vaccination requirements</i>) - I have an immune condition (e.g. HIV, transplant patient, spleen problem) - I am a man who has had sex with other men - I have diabetes / high blood pressure / heart / lung / liver / kidney disease - I am pregnant	<input type="checkbox"/> none of these are true <input type="checkbox"/> one or more of these are true (<i>explain</i>) - I have had an alcohol problem	
anything other significant history? <input type="checkbox"/> stayed in institution, for long-term physical/mental condition <input type="checkbox"/> had surgery before (including minor procedures) <input type="checkbox"/> I have committed/been accused of a crime (does not necessarily disqualify) <input type="checkbox"/> at least once a month, I take medication (including prescription or non-prescription medicine, herbals, supplements; creams/ eye-drops/ other non-oral; tobacco, alcohol, marijuana, etc.). List below; use the back of this page, or another paper, if needed.	<input type="checkbox"/> Nothing else	<input type="checkbox"/> other (<i>write explanation here</i>)
Sign here: _____		<input type="checkbox"/> signed by someone other than applicant (<i>write relationship here</i>) Date: _____

Immigrant Status Applicant Vaccination Questions

(form updated 2018-10-02)

Name: _____

- 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					
<input type="checkbox"/> I have brought medical records proving previous infection					
Measles					
Mumps <input type="checkbox"/> same dates as measles (leave this row blank)					
Rubella <input type="checkbox"/> same dates as measles (leave this row blank)					
Influenza virus (only most recent date needed)					
<i>Applicants aged 19-64 years only need to complete the lines above. Other applicants please also complete the following lines below.</i>					
Rotavirus					
Haemophilus influenzae b ("Hib", not flu virus)					
Hepatitis A					
Hepatitis B					
Meningitis					
Polio					
Pneumonia					

(signature/date)

Foster City Medical Center

Pregnancy and Your Immigration Application

This section should be read and signed by all female applicants aged 15-49 years.

If you are pregnant, some medical requirements for the immigration process can be waived. If you want to waive those requirements, you need to do a simple urine pregnancy test at our clinic.

We cannot accept pregnancy tests done elsewhere. We do not use blood pregnancy tests.

If you are not sure whether you are pregnant, you may do a urine pregnancy test with us, or you may wish to first do your own pregnancy test at home. (The cost of the pregnancy test is NOT included in the base price.)

You can do a pregnancy test only once with us for each immigration exam. (This prevents patients from repeating tests until a desired result is obtained.) If you wish to prove that you are pregnant but your home pregnancy test is negative, you may wish to wait a week until your home pregnancy test shows positive before doing the test at our clinic.

If you are pregnant, your medical requirements for the immigration process are affected as follows:

- you don't have to take the Measles/Mumps/Rubella vaccine, since this can harm the pregnancy
- you don't have to take the Varicella (chickenpox) vaccine, since this can harm the pregnancy

All other requirements continue to be in force, including (but not limited to) the following:

- you need the Tdap (tetanus/diphtheria/pertussis) vaccine
- you need the influenza (flu) vaccine, if during flu season
- you need to have a TB screening test
- you need an Xray, if the TB screening test is positive
- you need the physical examination and the mandatory blood/urine tests

You may choose to defer the vaccination, Xray or other procedure until after your pregnancy is finished, but this simply delays your paperwork, which cannot be completed until all the requirements are met. The risk to the fetus from the Xray/vaccine is decreased if you wait till you are three months pregnant, after the vulnerable first trimester.

Please sign in one of the two spaces below:

I choose NOT to take a pregnancy test at the clinic:

I believe that I am NOT pregnant, and will go through the immigration procedure as if I were not pregnant. I understand the consequences if I am wrong and am actually pregnant, including possible harm to the pregnancy if I obtain the vaccines above, etc.

Signature/Date: _____

I choose to take a pregnancy test at the clinic:

I am pregnant, or there is a possibility that I am pregnant. I understand that, if the pregnancy test shows that I am pregnant, the immigration exam requirements for pregnant applicants will apply. I understand that the fee for the pregnancy test is separate from the fee for the other services.

Signature/Date: _____

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 is a **TB blood test** (the TB skin test is no longer accepted by USCIS)
- if the screening test result is positive (abnormal), you will need the Xray
- prior TB vaccination (BCG) does not affect the TB blood test

- you may choose to skip the screening test and just do the Xray, if you have documentation showing a previous positive (abnormal) TB blood test result
- you may **not** skip the TB testing just because a test done elsewhere was normal, says USCIS

- 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 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. You 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.
- however, for statistical and epidemiologic tracking purposes, we are required to report your latent TB infection to the county public health department

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 county public health department is notified.

Foster City Medical Center

Optional Discount for Tuberculosis Testing for Immigration Applicants

Screening for **tuberculosis** (TB) is required by USCIS for any immigration ("green card") applicants of age 2 years or more (or, in some cases, even younger than age 2). This includes pregnant women, or patients who have had BCG vaccine, etc. Sometimes exceptions may be made for patients who can provide a record of previous **ABNORMAL** TB screening results. (USCIS does not accept previous normal results as a reason to skip the TB screening test.)

Starting October 1, 2018, this screening test must be done with a blood test (IGRA); the previous option of skin testing is no longer accepted.

The IGRA blood test is administered by Quest Diagnostics laboratory (Quest labs), or sometimes also other laboratories. The price of this testing is determined by the laboratory and is not within the control of Foster City Medical Center (FCMC clinic).

However, realizing that the price of TB blood tests is significant, we at FCMC clinic have urged Quest labs to give whatever discount might be available to immigration applicants who no longer have the choice of the lower cost skin test.

Quest labs has been able to make arrangements for a discounted price, on the condition that FCMC clinic be assigned the responsibility of collecting the fee for the TB blood test.

We at FCMC clinic can collect the discounted TB blood test fee only under the following conditions:

- the fee is paid in cash. No credit cards or cheques or other form of payment will be accepted.
- the fee is paid separately from any other fee that may be paid to FCMC clinic or Quest labs, such as the immigration exam fee or the fee for other blood tests done at Quest labs.
- the fee is paid prior to ordering the TB blood test. Once the TB blood test is ordered without the fee being paid, the discount will not apply, and applicants will need to pay Quest labs directly.
- there is no refund of the fee once the TB blood test is ordered, even if the test is not taken, since FCMC has committed to passing the fee on to Quest labs. A refund may or may not be obtainable from Quest labs, but this is outside the purview of FCMC clinic.

The arrangements involved in obtaining the discounted TB blood test fee are not mandatory, and green card applicants may reasonably expect to complete the examination process for the green cards without being subject to the above restrictions, by paying the usual non-discounted fee at Quest labs or other laboratory for the TB blood test.

If you wish to obtain a TB blood test by payment through FCMC clinic, please pay the fee as noted below, write the five-letter word "agree" in the blank indicated, then fill in your name and sign.

My name is _____, and I _____ (write "agree" or "do not agree") to the arrangements above, which I have read and understood, regarding arranging payment for the TB blood test through FCMC clinic, and have already paid the fee indicated.

Date: _____ Signature: _____

Fee: _____ Collected by: _____ (signature of staff)