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 07/31/2022

► **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. Gender ☐ 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 section. 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.** If applicable, select the box for **Item Number 2.**

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.

2. Applicant's Statement Regarding the Preparer

☐ At my request, the preparer named in **Part 4.**, _____, prepared this application for me based only upon information I provided or authorized.

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 Contact Information

3. Applicant's Daytime Telephone Number

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

5. Applicant's Email Address (if any)

Applicant's Certification

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

I furthermore 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 law.

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.

6. 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, if you used one.

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)

Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant

Provide the following information about the preparer.

Preparer's Full Name

1. Preparer's Family Name (Last Name)

Preparer's Given Name (First Name)

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

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

Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant (continued)

Preparer's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. ☐ ☐ ☐ Number

City or Town

State

ZIP Code

Province

Postal Code

Country

Preparer's Contact Information

4. Preparer's Daytime Telephone Number

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

6. Preparer's Email Address (if any)

Preparer's Statement

7. A. ☐ I am not an attorney or accredited representative but have prepared this application on behalf of the applicant and with the applicant's consent.

B. ☐ I am an attorney or accredited representative and my representation of the applicant in this case ☐ extends ☐ does not extend beyond the preparation of this application.

NOTE: If you are an attorney or accredited representative, you may need to submit a completed Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative, with this application.

Preparer's Certification

By my signature, I certify, under penalty of perjury, that I prepared this application at the request of the applicant. The applicant then reviewed this completed application and informed me that he or she understands all of the information contained in, and submitted with, his or her application, including the **Applicant's Certification**, and that all of this information is complete, true, and correct. I completed this application based only on information that the applicant provided to me or authorized me to obtain or use.

Preparer's Signature

8. Preparer's Signature

Date of Signature (mm/dd/yyyy)

Parts 5. - 10. of this form must be completed by the civil surgeon.

Part 5. Applicant's Identification Information (To be completed by the civil surgeon) (continued)

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 (circle): 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:**		**ZIP Code:**	**State:**
Occupation:	**Cell Phone Number:** ( )		**Home Phone Number:** ( )	
Primary Language:	**Social Security Number:**		Ok to leave private messages on cell phone voicemail (e.g. test results, etc.) ☐	

How did you hear about Foster City Medical Center?

☐ Family ☐ Friend ☐ Close to Home / Work ☐ Yelp ☐ 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. If this balance is not paid within two months then there will be a collection fee added, and I, the consumer, acknowledge responsibility for the payment of any collection fees added.

If a patient makes a payment on a bill online with HSA they need to send our billing department a copy of the payment to **lvmedicalcompliance@gmail.com**

☐ 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

+J9369s

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.
    - a sealed, signed envelope containing the I-693 form and necessary supporting documents
- 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.
- if, within 30 days, I am not able to have my blood drawn, Xrays taken, vaccines obtained, or any required test done or action taken, I may not be able to receive my documents. If the sealed, signed envelope is not picked up within 60 days of today's date, I may not receive it.
- 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 discount on the mandatory 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. Any applicant for whom the TB results are positive (abnormal) will need to do a chest Xray, including children and pregnant women. 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 from a different doctor, 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 09/03/19)

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? ❑ 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 for over a week
- ❑ 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.
- ❑ was in the same place as someone who had tuberculosis (TB)

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 diabetes / high blood pressure / heart / lung / liver / kidney disease
- 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 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.

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

Sign here: Date:

Immigrant Status Applicant Vaccination Questions

Name:

(form updated 2018-10-02)

- 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)

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: _____

(Form updated 2018-10-08)

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. 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.
- 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 Testing for Immigration Exam

Blood and urine testing for application for immigration status adjustment ("green card") is done by an independent laboratory, the cost of which is separate from the visit to see the Civil Surgeon. Generally, payment is made to the laboratory directly. Applicants have a choice of laboratory to use, though past experience shows that some laboratories work more smoothly with our clinic.

We at Foster City Medical Center ("FCMC") realize that the cost of testing can be significant. As a service to our patients, we have partnered with Quest Diagnostics to obtain a discount for the most commonly ordered tests. We offer the following OPTIONAL arrangement with Quest labs: you, the patient/ immigration applicant, would pay us, FCMC, a discounted fee. We in turn pay the laboratory. To take advantage of this option, please note the following details of this very specific arrangement:

- this is for specific tests, listed below, which are mandatory for immigration applicants. The tests are specific for a given age. We do not have arrangements in place for other tests or sets of tests. For any other testing, you would arrange payment with the laboratory directly.
- this is with Quest Diagnostics in northern California. We do not have arrangements in place with other laboratories.
- the decision for *discount* or *no discount* cannot be changed once the tests are ordered. There is no refund of the fee once the tests are ordered, even if the tests are not taken, since FCMC has committed to paying Quest for the tests.
- the fee is pre-set, and is independent of any other prices, discounts or changes available through other means. We cannot guarantee that our option is always the lowest in price.
- this arrangement is optional, and patients may reasonably expect to complete their testing for immigration without this arrangement, by making payment to the laboratory directly.

Set of Tests:	**Set A** (15 years and older)	**Set B** (less than 15 years old)
Tests included:	1) QuantiFERON-TB blood test 2) RPR blood test for syphilis 3) gonorrhea urine test	1) QuantiFERON-TB blood test
Price:	$240	$180

If you wish to pay for these tests through FCMC clinic, please write the five-letter word "agree" where indicated, then fill in the form and sign. We accept payment by credit card or cash.

(check one box below)

Set of Tests: ☐ - **Set A** (3 tests, listed above, for patients 15 years old or older)
☐ - **Set B** (only TB blood test, as above, for patients under 15 years old)

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 testing through FCMC clinic, and have paid the fee appropriate for the patient age.

Date:_____ Signature: _____

Office use only:
☐- *credit card*
☐- *cash*

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

(form updated 2019-09-03)