Report of Immigration Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2025

► **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 Legal Name (**Do not** provide a nickname)

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

2. Current Physical Address *(USPS ZIP Code Lookup)*

In Care Of Name (if any)

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

City or Town | State | ZIP Code

Province | Postal Code | Country

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)
►

4. Immigration Medical Examination Requirement

A. ☐ I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

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

Applicant's Contact Information

Provide your daytime telephone number, mobile telephone number (if any), and email address (if any).

1. Applicant's Daytime Telephone Number

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

3. Applicant's Email Address (if any)

Applicant's Certification and Signature

I certify, under penalty of perjury, that I provided or authorized all of the responses and information contained in and submitted with my application, I read and understand or, if interpreted to me in a language in which I am fluent by the interpreter listed in **Part 3.**, understood, all of the responses and information contained in, and submitted with, my form, and that all of the responses and the information are complete, true, and correct. I understand the purpose of this immigration 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 immigration medical examination, I understand that any immigration benefit I derived from this immigration 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. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for an immigration request and to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

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

4. Applicant's Signature

Date of Signature (mm/dd/yyyy)

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

Interpreter's Full Name

1. Interpreter's Family Name (Last Name)

Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

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

5. Interpreter's Email Address (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 Certification and Signature

I certify, under penalty of perjury, that I am fluent in English and [ ], and I have interpreted every question on the application and Instructions and interpreted the applicant's answers to the questions in that language, and the applicant informed me that they understood every instruction, question, and answer on the application.

6. 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

Preparer's Full Name

1. Preparer's Family Name (Last Name)
HUSSEIN

Preparer's Given Name (First Name)
HANAN

2. Preparer's Business or Organization Name
LEAGUE CITY FAMILY CLINIC

Preparer's Contact Information

3. Preparer's Daytime Telephone Number
2815256290

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

5. Preparer's Email Address (if any)
INFO@LEAGUECITYFAMILYCLINIC.COM

Preparer's Certification and Signature

I certify, under penalty of perjury, that I prepared this application for the applicant at their request and with express consent and that all of the responses and information contained in and submitted with the application are complete, true, and correct and reflects only information provided by the applicant. The applicant reviewed the responses and information and informed me that they understand the responses and information in or submitted with the application.

6. 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)

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

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

Part 6. Summary of Medical Examination (To be completed by the civil surgeon)

1. Summary of Overall Findings:

A. ☒ No Class A or Class B Condition

B. ☐ Class B Conditions (See **Item Numbers 1. - 4.** in **Part 8. Civil Surgeon Worksheet**)

C. ☐ Class A Conditions (See **Item Numbers 1. - 3. i**n **Part 8. Civil Surgeon Worksheet**)

2. Date of First Examination (Date applicant signed in **Part 2.)**
(mm/dd/yyyy)

3. Dates of Follow-up Examinations, if required:

Date of Examination (mm/dd/yyyy) | Date of Examination (mm/dd/yyyy) | Date of Examination (mm/dd/yyyy)

Part 7. Civil Surgeon's Contact Information, Certification, and Signature

NOTE: Do not sign Form I-693 until all health-related follow-up requirements are met.

Civil Surgeon's Information

1. Family Name (Last Name): **HUSSEIN**
Given Name (First Name): **HANAN**
Middle Name (if applicable):

Civil Surgeon Identification Number (CSID) (unless performing the examination under a health department or military blanket designation): **109985**

2. Name of Medical Practice, Facility, or Health Department: **LEAGUE CITY FAMILY CLINIC**

Physical Address

3. Street Number and Name: **1507 W. LEAGUE CITY PARKWAY #200**
Apt. Ste. Flr. Number:

City or Town: **LEAGUE CITY**
State: **TX**
ZIP Code: **77573**

Mailing Address

4. Street Number and Name (PO Box): **AS ABOVE**
Apt. Ste. Flr. Number (if applicable):

City or Town:
State:
ZIP Code:

Contact Information

5. Daytime Telephone Number: **2815256290**

6. Mobile Telephone Number (if any):

7. Email Address (if any): **INFO@LEAGUECITYFAMILYCLINIC.COM**

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

Part 7. Civil Surgeon's Contact Information, Certification, and Signature (continued)

Civil Surgeon's Certification

I certify under penalty of perjury under United States law that:

I am a civil surgeon designated to examine applicants seeking certain immigration benefits in the United States OR a physician who qualifies under a blanket designation specified by policy or law;

I have a currently valid and unrestricted license to practice medicine in the state where I am performing immigration medical examinations, unless otherwise exempted;

I have not had my license to practice medicine revoked, and I am not subject to any restrictions on any license to practice medicine in any other jurisdiction in the United States in which I conduct immigration medical examinations.

I performed an examination of the person identified in **Part 1.** of this Form I-693, after having made every reasonable effort to verify that the person whom I examined is in fact the person identified in **Part 1.**;

I performed the examination in accordance with the Centers for Disease Control and Prevention's (CDC) *Technical Instructions for Civil Surgeons*, as well as all supplemental information or updates; and

All the information I provided on this Form I-693 is complete, true, and correct, based on the information provided to me by the applicant.

Civil Surgeon's Signature

8. Civil Surgeon's Signature

Date of Signature (mm/dd/yyyy)

(Health departments and military treatment facilities MUST place their official stamp or seal here.)

(official stamp or seal here)

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

Part 8. Civil Surgeon Worksheet

(To be completed by the civil surgeon, according to the *Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/tuberculosis.html**.)

1. Communicable Disease of Public Health Significance

A. Tuberculosis (TB): An initial screening test, an interferon gamma release assay (IGRA), is required for all applicants 2 years of age and older; for children under 2 years of age, see the *Technical Instructions for Civil Surgeons*. The civil surgeon will perform further evaluation if needed (chest X-ray).

(1) Interferon Gamma Release Assay (for acceptable IGRAs, consult the *Technical Instructions for Civil Surgeons* and any updates posted on the CDC's website):

☒ Not Administered (IGRA exception; please explain in Remarks section below)

Select **only one** box.

☒ QuantiFERON

Date Blood Sample Drawn (mm/dd/yyyy)

☐ T-Spot

Date Blood Sample Drawn (mm/dd/yyyy)

Result: ☒ Negative (no chest X-ray required)

☐ Positive (chest X-ray required)

☐ Indeterminate (including borderline/equivocal) (no chest X-ray required)

(2) Initial Screening Test Result and Chest X-Ray Determinations:

☒ Chest X-ray not required (medically cleared for TB).

☐ Chest X-ray required due to initial screening test results.

☐ Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (such as HIV).

☐ Chest X-ray required due to IGRA exception (Clearly specify the IGRA exception in the Remarks section below.).

Sputum Smears and Cultures Results

(3) Chest X-Ray: Required based on IGRA result, or if specific IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (such as HIV).

Date Chest X-Ray Taken (mm/dd/yyyy)

Date Chest X-Ray Read (mm/dd/yyyy)

Result: ☐ Normal

☐ Abnormal findings suggestive of TB that require smears and cultures:

- ☐ Infiltrate or consolidation
- ☐ Reticular markings suggestive of fibrosis
- ☐ Cavitary lesion
- ☐ Nodule(s) or mass with poorly defined margins (*such as tuberculoma)*
- ☐ Pleural effusion
- ☐ Hilar/mediastinal adenopathy
- ☐ Miliary findings
- ☐ Discrete linear opacity
- ☐ Discrete nodule(s) without calcification
- ☐ Volume loss or retraction
- ☐ Irregular thick pleural reaction
- ☐ Other (further describe in Remarks section below)

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

Part 8. Civil Surgeon Worksheet (continued)

(4) Sputum Smears and Cultures Decision

- ☒ No, not indicated.
- ☐ Yes, indicated due to signs or symptoms of TB.
- ☐ Yes, indicated due to chest X-ray suggestive of TB.
- ☐ Yes, indicated due to known HIV infection or extrapulmonary TB.
- ☐ Yes, indicated for end of treatment cultures.

(5) Sputum Smears and Cultures Results

Sputum Smear Results				
Date Specimen Obtained (mm/dd/yyyy)		**Date Smear Result Reported** (mm/dd/yyyy)	**Positive**	**Negative**
1.				
2.				
3.				

Sputum Culture Results						
Date Specimen Obtained (mm/dd/yyyy)		**Date Culture Result Reported** (mm/dd/yyyy)	**Positive**	**Negative**	**NTM**	**Contaminated**
1.						
2.						
3.						

(6) TB Classification/Findings (Select only if chest X-ray was performed.):

- ☒ No Class A or Class B TB
- ☐ Class A Pulmonary TB Disease
- ☐ Class B0 Pulmonary TB
- ☐ Class B1 Pulmonary TB
- ☐ Class B1 Extrapulmonary TB
- ☐ Class B2 TB, Latent TB Infection
- ☐ Class B, Other Chest Condition (non-TB)

(7) Remarks: (Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform IGRA, give the reason why an exception applies.)

N/A

B. Syphilis

(1) Serologic Test for Syphilis (Required for applicants 18 to 44 years of age - see CDC's *Syphilis Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/syphilis.html** for current required testing age range). All tests must be performed on the same blood sample.

(a) Name of Nontreponemal Test: RPR, non-treponemal

(b) Date Nontreponemal Test Collected (mm/dd/yyyy):

(c) ☒ Nontreponemal Test Nonreactive Date Reported (mm/dd/yyyy):

☐ Screening Reactive, Titer 1:

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

Part 8. Civil Surgeon Worksheet (continued)

(d) Name of Treponemal Test: N/A

(e) Date Treponemal Test Reported (mm/dd/yyyy):

(f) ☐ Treponemal Test Nonreactive ☐ Treponemal Test Reactive

(g) If using reverse algorithm and treponemal test reactive but nontreponemal test nonreactive: Name of Repeat Treponemal Test (preferably one based on different antigens):

(h) Date Repeat Treponemal Test Reported (mm/dd/yyyy):

(i) ☐ Repeat Treponemal Test Nonreactive ☐ Repeat Treponemal Test Reactive

(2) Findings:

☒ No Class A or Class B Syphilis ☐ Syphilis, Class A (untreated) ☐ Syphilis, Class B (treated in the last year)

(3) Remarks: (Include stage of syphilis diagnosed [primary, secondary, early latent, late latent or latent of unknown duration, tertiary, neurosyphilis, congential] and any therapy given with doses and dates of administration.)

Drug: Dosage:

Start Date (mm/dd/yyyy): End Date (mm/dd/yyyy):

C. Gonorrhea

(1) Laboratory Test for Gonorrhea (Required for applicants 18 to 24 years of age - see CDC's *Gonorrhea Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/gonorrhea.html** for current required testing age range.)

(a) Screening Nucleic Acid Amplification Test (NAAT) Name: NEISSERIA GONORRHOEAE, APTIMA

(b) Date Result Reported (mm/dd/yyyy):

(c) ☐ Positive ☒ Negative

(2) Findings:

☒ No Class A or Class B Gonorrhea ☐ Gonorrhea, Class A (untreated)

☐ Gonorrhea, Class B (treated in the last year)

(3) Remarks: (Include any symptoms or treatment given with doses and dates of administration.)

N/A

Drug: Dosage:

Start Date (mm/dd/yyyy): End Date (mm/dd/yyyy):

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

Part 8. Civil Surgeon Worksheet (continued)

D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance**.** For instructions, see the CDC's *Technical Instructions for Civil Surgeons* for Hansen's Disease at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/hansens-disease.html**.

(1) Findings:

(a) ☒ No Class A/B Condition

(b) ☐ Hansen's Disease (leprosy, any classification) untreated, Class A

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(c) ☐ Hansen's Disease (leprosy, any classification) treated or partially treated, Class B

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(2) Remarks: **(**If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**. Include any therapy given and any counseling or referrals.)

2. Physical or Mental Disorders With Associated Harmful Behavior

Include here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category of physical or mental disorders includes any diagnosis of substance-use disorders that involve any substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, diagnosis of an alcohol-use disorder). Diagnose mental disorders according to the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. Diagnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's Manual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) or another authoritative source as determined by the director of the CDC. See the CDC's *Technical Instructions for Civil Surgeons* for Other Physical or Mental Abnormality, Disease or Disability at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/other-physical-or-mental-abnormality-disease.html** for more information.

A. Findings:

(1) ☒ No Class A or B Physical or Mental Disorder

(2) ☐ Physical/Mental Disorder with Associated Harmful Behavior, Class A

(3) ☐ Physical/Mental Disorder with a History of Associated Harmful Behavior Likely to Recur, Class A

(4) ☐ Physical/Mental Disorder without Associated Harmful Behavior, Class B

(5) ☐ Physical/Mental Disorder with a History of Associated Harmful Behavior Unlikely to Recur, Class B

B. Remarks: (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**.)

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

Part 8. Civil Surgeon Worksheet (continued)

3. Drug Abuse/Drug Addiction

The U.S. Department of Health and Human Services (DHHS) sets the medical guidelines for determining drug abuse and drug addiction. The terms are defined at 42 CFR 34.2(h) and (i).

Include here any diagnosis of drug abuse or drug addiction.

"Drug abuse or drug addiction" is "current substance use disorder mild, moderate or severe" **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM, or by another authoritative source as determined by the director of the CDC.

You may also make a diagnosis of full remission, according to the diagnostic criteria in the most current edition of the DSM or another authoritative source as determined by the director of the CDC. See the CDC's *Technical Instructions for Civil Surgeons* for Mental Health at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/mental-health.html** for more information.

A. Findings:

(1) ☒ No Class A or B Substance (Drug) Abuse/Addiction

(2) ☐ Substance (Drug) **Abuse or Addiction**, listed in section 202 of the Controlled Substances Act, Class A

(3) ☐ Substance (Drug) **Abuse** in Full Remission, listed in section 202 of the Controlled Substances Act, Class B

(4) ☐ Substance (Drug) **Addiction** in Full Remission, listed in section 202 of the Controlled Substances Act, Class B

B. Remarks: (Include any therapy given and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**.)

N/A

4. Other Medical Conditions (List any other Class B conditions, such as hypertension or diabetes, and all required evaluation components as found in CDC's *Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/medical-history-physical-examination.html**.)

N/A

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

Part 8. Civil Surgeon Worksheet (continued)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if a referral is medically required.)

A. Type or Print Name of Doctor or Health Department Receiving Required Referral

B. Address

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

City or Town | State | ZIP Code

C. Date of Referral (mm/dd/yyyy)

D. Remarks: (Include the name of medical condition and the reasons for referral. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**.)

Part 9. Referral Evaluation (To be completed by the health department or other doctor performing the referral evaluation.)

The applicant identified on this Form I-693 was referred to me by the civil surgeon named in **Part 7.** of this Form I-693. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I have evaluated/ treated is the person identified in **Part 1.**

1. Evaluating Physician or Health Department's Full Name

A. Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

B. Health Department 's Name

2. Address

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

City or Town | State | ZIP Code

3. Signature of Health Department Individual or Other Doctor Performing Referral Evaluation

Signature | Date Signed (mm/dd/yyyy)

4. Name of Medical Practice or Health Department

5. Daytime Telephone Number

NOTE: If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**.

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

Part 10. Vaccination Record

NOTE: See *Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/index.html** for a list of required vaccines, and **www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/vaccination.html** for COVID-19 specific vaccine guidance.

Please make sure to mark every row. Reserve all comments for the Remarks section below. **For applicants who only require a vaccination assessment:** Submit only this Part with **Parts 1. - 5.**, and **Part 7.** of Form I-693. (If you need an interpreter, complete **Part 3. Interpreter's Contact Information, Certification, and Signature**.) For more information, see Form I-693 Instructions, **Frequently Asked Questions.**

Vaccine History Transferred From A Written Record					**Vaccine Given**	**Complete Series**	**Blanket Waiver(s) to be Requested from USCIS (Not Medically Appropriate)**			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark "X" if complete; write date of lab test if immune or "VH" if varicella history	Not Age - Appropriate	Contra-indication	Insufficient Time Interval	*See Below Table
Specify Vaccine: ☐ DT ☐ DTaP ☐ DTP							☒	☐	☐	
Specify Vaccine: ☐ Td ☒ Tdap							☐	☐	☐	
Specify Vaccine: ☐ OPV ☒ IPV							☐	☐	☐	
MMR (measles, mumps, rubella) or, if monovalent or other combination of the vaccines are given, specify vaccines							☐	☐	☐	
Hib							☒	☐	☐	
Hepatitis B							☐	☐	☐	
Varicella							☐	☐	☐	
Pneumococcal							☒	☐	☐	
Influenza							☐	☐	☐	☐
Rotavirus							☒	☐	☐	
Hepatitis A							☒	☐	☐	
Meningococcal							☒	☐	☐	
COVID-19 (In "Remarks" section, write "COVID-19" and specify vaccine brand)							☐	☐	☐	☒

NOTE: Give a copy to the applicant.

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

Part 10. Vaccination Record (continued)

***For influenza vaccine**, check the box in this column only if vaccine is not available in the location where the civil surgeon practices. The civil surgeon is responsible for knowing local availability of the influenza vaccine.

***For COVID-19 vaccine**, check the box in this column only if vaccine is not routinely available in the location where the civil surgeon practices according to the *Technical Instructions for Civil Surgeons* blanket waivers for this vaccine.

Results:

- ☒ Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above.
- ☐ Applicant will request an individual waiver based on religious or moral convictions.
- ☐ Applicant does not meet immunization requirements.

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

Influenza-applicable September-April

Per USCIS-effective 01/22/2025 COVID vaccine no longer required.

FOR USCIS USE ONLY

Remarks (if any)

Part 11. Additional Information

If you (the applicant or the civil surgeon) need extra space to provide any additional information within this form use the space below. If you (the applicant or civil surgeon) need more space than what is provided, you may make copies of this page to complete and file with this form or attach a separate sheet of paper. Type or print the applicant's name and A-Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet.

1. Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. A-Number (if any) ► **A-**

3. **A.** Page Number **B.** Part Number **C.** Item Number

D.

4. **A.** Page Number **B.** Part Number **C.** Item Number

D.

5. **A.** Page Number **B.** Part Number **C.** Item Number

D.

6. **A.** Page Number **B.** Part Number **C.** Item Number

D.