Supplement 1,
Applicants With a Class A Tuberculosis Condition
(As Defined by Health and Human Services Regulations)

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

USCIS
Form I-690
OMB No. 1615-0032
Expires 12/31/2023

Part 1. Applicant's Information

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

2. Alien Registration Number (A-Number) (if any)
► **A-**

3. USCIS Online Account Number (if any)
►

Part 2. Responsibilities of Applicant's Sponsor in the United States

The responsibilities of the applicant's sponsor in the United States are to make arrangements for the applicant's medical care, have the attending physician or facility complete **Part 4.**, and to obtain the necessary endorsements: endorsement of a local health department if providing treatment, endorsement of a private physician or other private or public facility if providing treatment, and endorsement of a State Health Department Official.

If a local health department will provide the necessary care and/or treatment to the applicant, that facility should select the appropriate checkbox **in Part 4.**, **Item A.** in **Item Number 1.**

If a private physician, private medical facility, or public medical facility (other than a local health department) will provide the applicant's medical care and/or treatment, that facility should select the appropriate checkbox in **Part 4.**, **Item Number 1.**

If a State Health Department Official will provide the necessary care and/or treatment, that facility should complete **Part 5.**

1. Provide the physical address in the United States where the applicant plans to reside. ***(USPS ZIP Code Lookup)***

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

City or Town | State | ZIP Code

Part 3. Applicant's Statement

Upon admission to the United States, I will:

Go directly to the physician named **in Part 4.**, **Item Number 2.** or health facility named **in Part 4.**, **Item Number 3.**; present copies of diagnostic tests used during my visa examination to verify my diagnosis; attend counseling, examinations, treatment, and medical regimen as required; and remain under prescribed treatment or observation, regardless of inpatient or outpatient basis, until I am discharged.

1. Applicant's Signature | Date of Signature (mm/dd/yyyy)

Part 4. Statement by Physician or Health Facility

I agree to supply counseling and any treatment or observation necessary for the proper management and continued care of the applicant's tuberculosis condition.

I agree to submit a summary of my initial evaluation of the applicant's condition, indicating presumptive diagnosis, test results, and plans for the applicant's future care, to:

Division of Global Migration and Quarantine (E03)
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, Georgia 30329-4027

I will submit the summary referenced above within 30 days of the date the applicant is required to appear for evaluation and/or care, and if at the end of the 30-day period the applicant fails to appear for evaluation and/or care as required, I will submit a report to notify the Center for Disease Control and Prevention (CDC) and the health official indicated in **Part 5.** of the applicant's failure to appear.

I agree that satisfactory financial arrangements have been made for the applicant's medical care and treatment. (The applicant must still submit evidence, as required by the consular officer or U.S. Citizenship and Immigration Services (USCIS), to establish that he or she is unlikely to become a public charge (another ground of inadmissibility under Immigration and Nationality Act (INA) section 212(a)(4)).

1. I represent (select **only one** box):

- ☐ Local Health Department
- ☐ Other Public Health Facility
- ☐ Private Medical Practice

I agree to submit a copy of my evaluation to the health official indicated in **Part 5.**

2. Name of Physician

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

3. Name of Facility

4. Address of Physician or Facility

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

City or Town	State	ZIP Code

5. Signature of Physician

Signature of Physician	Date of Signature (mm/dd/yyyy)

Part 5. Endorsement of State Health Department Official

Your endorsement signifies that you recognize the physician or facility providing the applicant's treatment for tuberculosis. If the facility physician who signed in **Part 4.** is not in your health jurisdiction or is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction, and/or the physician, before you sign this endorsement.

1. Official Name of Department

2. Name of Official Providing Endorsement

3. Title of Official Providing Endorsement

4. Signature of State Health Department Official

Date of Signature (mm/dd/yyyy)

5. Address of Health Department

Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code