Application for Civil Surgeon Designation

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

USCIS
Form I-910
OMB No. 1615-0114
Expires 10/31/2015

For USCIS Use Only	Initial Receipt		Barcode	Action Block
	Resubmitted			
	Relocated			
	Received	Sent		
Remarks				CSID Number:

To Be Completed by an *Attorney or Accredited Representative*, if any.	☐ Select the box if Form G-28 is attached to represent the applicant.	Attorney State License Number: _____

► **START HERE - Type or print in black ink.**

Part 1. For Previously Designated Civil Surgeons

1.a. Have you ever been designated as a civil surgeon before?

☐ Yes ☐ No

If you selected "Yes," provide the following information:

1.b. Period of Designation *(mm/dd/yyyy)*
From ► To ►

1.c. USCIS Office that granted the designation

1.d. Civil Surgeon Identification Number *(if known)*

2.a. Has USCIS ever revoked your designation?

☐ Yes ☐ No

If you selected "Yes," provide the following information:

2.b. Date of Revocation *(mm/dd/yyyy)* ►

3.a. Have you ever voluntarily terminated your designation?

☐ Yes ☐ No

If you selected "Yes," provide the following information:

3.b. Date of Voluntary Termination *(mm/dd/yyyy)* ►

NOTE: If you select "Yes" to **Item Number 2.a.** or **3.a.** above, please include a written explanation of the circumstances surrounding the revocation or voluntary termination, in a separate letter attached to this application or in **Part 10., Additional Information**.

Part 2. Information About You *(Physician requesting designation or renewal)*

Your Full Name

1.a. Family Name *(Last Name)*

1.b. Given Name *(First Name)*

1.c. Middle Name

Other Information

2. Date of Birth *(mm/dd/yyyy)* ►

Part 3. Clinical Office Location(s)

Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical exams in more than one location, provide the details for each additional location in **Part 10., Additional Information.**

A. Required Information

You must provide the following information. Failure to provide this information may result in the denial of your application. Please refer to **Part 2., Section B** for more information about what will be made publicly available.

1. Name of Clinic/Practice

Part 3. Clinical Office Locations *(continued)*

Physical Address of the Clinic/Practice

2.a. Street Number and Name

2.b. Apt. ☐ Ste. ☐ Flr. ☐

2.c. City or Town

2.d. State **2.e.** ZIP Code

3. Telephone Number

4. Fax Number

5. E-Mail Address *(For use by USCIS)*

NOTE: USCIS will use the contact information listed above for all civil surgeon-related communication.

UPDATE USCIS OF ANY CHANGES: Civil surgeons are responsible for notifying USCIS in writing of any updates to the contact information provided in this form **within 15 days of the change.** Visit the USCIS web site at **www.uscis.gov/I-910** for information on how to submit a change.

B. Optional Information

Providing the following information is **optional**. Your application will not be affected if you choose not to provide this information. If and when feasible, USCIS may provide this information, in addition to the required information above, as part of the public civil surgeon list. To submit additional information, please check the relevant boxes below and provide the requested details:

1. ☐ E-Mail Address *(For use by the public)*

2. ☐ Web Site Address *(URL)*

3. ☐ Fees for Medical Examination

4. ☐ Acceptable Means of Payment

5. ☐ Languages Spoken

6. ☐ Other

Part 4. Information About Your Status in the United States

You must be authorized to work in the United States to be eligible for civil surgeon designation.

1. ☐ I am a U.S. citizen or national *(Attach proof that you are a U.S. citizen, such as a copy of a U.S. passport, birth certificate, or Certificate of Naturalization.)*

2. ☐ I am a Legal Permanent Resident *(Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to extend your Form I-551, attach evidence thereof.)*

3. ☐ I am currently present in the United States as a nonimmigrant *(Provide a copy of your Form I-94 Arrival/Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application.)*

3.a. Date of Last Arrival in the U.S. *(mm/dd/yyyy)*▶

3.b. Form I-94 Arrival/ Departure Record Number *(If any)* ▶

3.c. Passport Number

3.d. Travel Document Number

3.e. Country of Issuance for Passport or Travel Document

3.f. Expiration Date for Passport or Travel Document *(mm/dd/yyyy)*▶

3.g. Current Nonimmigrant Status

Part 4. Information About Your Status in the United States *(continued)*

4. ☐ Other status granted that would allow you to practice medicine in the United States:

Part 5. Medical License(s)

You must be licensed to practice medicine in the state or territory in which you seek to perform immigration medical examinations to be eligible for civil surgeon designation. **Attach a copy of the medical license(s) listed below.**

Medical License 1:

1.a. State **OR**

U.S. Territory

1.b. Medical License Number

1.c. Date Issued *(mm/dd/yyyy)* ▶

1.d. Date Expires *(mm/dd/yyyy)* ▶

Medical License 2:

2.a. State **OR**

U.S. Territory

2.b. Medical License Number

2.c. Date Issued *(mm/dd/yyyy)* ▶

2.d. Date Expires *(mm/dd/yyyy)* ▶

Part 6. Medical Degree(s)

You must be a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to be eligible for civil surgeon designation. **Attach a copy of the medical degree(s) listed below.**

School 1:

1.a. School

1.b. Dates of Attendance *(mm/dd/yyyy)*
From ▶ To ▶

1.c. Degree

School 2:

2.a. School

2.b. Dates of Attendance *(mm/dd/yyyy)*
From ▶ To ▶

2.c. Degree

Part 7. Professional Experience

You must establish at least 4 years of professional experience to be eligible for designation. **NOTE:** Time spent in a post-medical school training (including internships or residency programs) cannot be counted toward this experience requirement. **Please attach evidence to verify your professional experience, such as evaluations, certificates of completion, or letters of employment verification.**

Employer 1:

1.a. Employer

1.b. Dates of Employment *(mm/dd/yyyy)*
From ▶ To ▶

1.c. Contact Information

Employer 2:

2.a. Employer

2.b. Dates of Employment *(mm/dd/yyyy)*
From ▶ To ▶

2.c. Contact Information

Part 8. Signature of Applicant

By signing this form, I accept civil surgeon designation if my request for designation is granted. Once designated a civil surgeon, I agree that I will perform the medical examinations according to the regulations published by Health and Human Services (HHS) at 42 CFR part 34 and the *Technical Instructions for Civil Surgeons* by the Centers for Disease Control and Prevention (CDC), including periodic updates.

By signing this form, I further agree to comply fully with the regulations at 8 CFR part 232. I understand that USCIS reserves the right to revoke civil surgeon designation in certain circumstances.

I certify, under penalty of perjury under the laws of the United States of America, that the information provided with this request is all true and correct. I authorize the release of any information from my records which USCIS deems necessary in order to determine my eligibility for designation as a civil surgeon.

1. Signature of Applicant

2. Date of Signature *(mm/dd/yyyy)* ►

Part 9. Signature of Person Preparing This Application, If Other Than Applicant

Attorney or Representative Only: In the event of a Request for Evidence (RFE), may USCIS contact you by fax or e-mail?

☐ Yes ☐ No

Preparer's Information

Provide the following information concerning the preparer:

1.a. Preparer's Family Name *(Last Name)*

1.b. Preparer's Given Name *(First Name)*

2. Preparer's Business or Organization Name

3.a. Street Number and Name

3.b. Apt. ☐ Ste. ☐ Flr. ☐

3.c. City or Town

3.d. State **3.e.** ZIP Code

4.a. Preparer's Daytime Phone Number

4.b. Preparer's E-mail Address *(if any)*

5. ☐ Check here if the applicant has authorized you to be a secondary point of contact for communications related to civil surgeon designation.

Declaration

I declare that this document was prepared by me at the request of the applicant and it is based on all information of which I have knowledge and/or was provided to me by the applicant in response to the exact questions contained on this form. I have not knowingly withheld any information.

6.a. Signature of Preparer

6.b. Date of Signature *(mm/dd/yyyy)* ►

Part 10. Additional Information

If needed, you may use the space below to provide additional information relevant to this application. Please provide the **Page Number**, **Part Number**, and **Item Number** to which the additional information relates.

Your Full Name

1.a. Family Name *(Last Name)*

1.b. Given Name *(First Name)*

1.c. Middle Name

2.a. Page Number **2.b.** Part Number **2.c.** Item Number

2.d.

3.a. Page Number **3.b.** Part Number **3.c.** Item Number

3.d.

4.a. Page Number **4.b.** Part Number **4.c.** Item Number

4.d.

5.a. Page Number **5.b.** Part Number **5.c.** Item Number

5.d.

6.a. Page Number **6.b.** Part Number **6.c.** Item Number

6.d.