ALL parts of this form, except the "APPLICANT ATTESTATION" and "INTERPRETER'S CERTIFICATION" must be certified by a licensed medical professional as provided in the instructions for Form N-648. Before certifying this form, the medical professional must conduct an in-person examination of the applicant. (See instructions for Form N-648 for additional information which is also located in the "FORMS" section at <a href="https://www.uscis.gov">www.uscis.gov</a>.)

## **Reminder About Eligibility Requirements**

This form is intended for an applicant who seeks an exception to the English and/or civics requirements due to a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more. An applicant who with reasonable accommodations provided under the Rehabilitation Act of 1973 can satisfy the English and civics requirements does not need to submit this form. Reasonable accommodations include, but are not limited to, sign language interpreters, extended time for testing, and off-site testing.

## **Completing and Certifying This Form**

All questions or items must be answered fully and accurately. Responses should utilize common terminology, without abbreviations, that a person without medical training can understand. U.S. Citizenship and Immigration Services (USCIS) recommends that the certifying medical professional use the electronic Form N-648 located in the "FORMS" section **www.uscis.gov**. If the medical professional completes the form by hand, then responses must be legible and appear in black ink.

Type or print clearly in black ink.

Part I. APPLICANT INFORMATION					USCIS USE ONLY	
I certify that I have examined:						This N-648 is:
Last Name First Name Mide			ddle Name USCI A-		S A-Number	☐ Sufficient ☐ Insufficient ☐ Continued/RFE
Address (Street Number and Name)  U.S. Social Security Number						Reviewer
City		Sta	State or Province		Zip Code or Postal Code	Location & Date
Telephone Number E-Mail Address (if any)			Date of Birth		Gender  Male Female	

## Part II. MEDICAL PROFESSIONAL INFORMATION

Type or print clearly in black ink. If you need more space to complete an answer, use a separate sheet of paper. Write the applicant's name and Alien Registration Number (A-Number), at the top of each sheet of paper and indicate the part and number of the item to which the answer refers. You must sign and date each continuation sheet. You must answer and complete each question since USCIS will not accept an incomplete Form N-648. You may, but are not required to, attach to this completed form supportive medical diagnostic reports or records regarding the applicant.

**NOTE:** Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of Guam, Puerto Rico, and the Virgin Islands) are authorized to certify the form. While staff of the medical practice associated with the medical professional certifying the form may assist in its completion, the medical professional is responsible for the accuracy of the form's content.

Last Name	First Name		Middle Name			
Business Address (Street Number and Name)	City	State or Province	Zip Code or Postal Code	Telephone Number		
License Number Licensing State		E-Mail Address (if any)				
1. Currently licensed as a (Check all that apply):	Medical Doctor	Doctor of Osteop	pathy   Clinical P	sychologist		
2. Medical practice type:						

Applicant's Name		USCIS A-Number
		<b>A</b> -
Dort III INFODM	ATION ABOUT DISABILITY and/or IMPA	IDMENT/C)
seeking an exception		nt's disability and/or impairment(s) that form the basis for IV 318.0 Down syndrome". If you cannot provide a DSM IV
	iption of the disability and/or impairment(s), e.g., "Dov (also referred to as mental retardation), developmenta	
	ed the applicant regarding the condition(s) listed in nu	
Date (mm/dd/yyyy)	Location (if different from business address on Page 1; otherw	ise write "same as business address")
4. Date you last examine	d the applicant regarding the condition(s) listed in nun	nber 1, if different from above.
Date (mm/dd/yyyy)	Location (if different from business address on Page 1; otherw	ise write "same as business address")
5. Are you the medical p	rofessional regularly treating this applicant for the con	ndition(s) listed in Item Number 1?
Yes (If "Yes," ind	icate duration of treatment.) Years Mon	ths
	ide the name of the applicant's regularly treating medical ead of the regularly treating medical professional.)	professional on the next page and explain why you are certifying

		<u> </u>	·	<u> </u>	<u> </u>	
Appli	cant's Name	USCIS A-Number A-				
Name	of Regularly Treating Medical Profession	al and Address.				
Last I		First Name		Middle Name		
Busin	ess Address (Street Number and Name)	City State or Province		Zip Code or Postal Code	Telephone Number	
Explai	nation					
	Yes (If "Yes," continue to complete this for  No (If "No," the applicant is not eligible for the "Medical Professional's Certificati  the applicant's disability and/or impairment  Yes (If "Yes," the applicant is not eligible the "Medical Professional's Certificant  No (If "No," continue to complete this form that caused this applicant's medical disability	or this exception and you need n ion.")  nt(s) the result of the applicant for this exception and you need tion.")  n.)	's illegal use of dr	rugs? emainder of the question.		

Applicant's Name	USCIS A-Number				
	A-				
9. What clinical methods did you use to diagnose the applicant's medical disability and/or impairment(s) listed in number 1?					
10. Clearly describe how the applicant's disability and/or impairment(s) affect his or her ability to demonstrate knowledge and understanding of English and/or civics.					
11. In your professional medical opinion, does the applicant's disability or impairment(s) prevent following requirements? (Check all that apply. If none applies, the applicant is not eligible for this					
The ability to:					
Read English					
☐ Write English					
Speak English					
Answer questions regarding United States history and civics, even in a language the applicant un	derstands.				

Applicant's Name		USCIS A-Number A-
12. Was an interpreter used during your examination of th		
<ul><li>☐ Yes (If "Yes," the interpreter must complete the "Inte</li><li>☐ No</li></ul>	rpreter Certification" section.)	
Additional Comments (Optional)		
MEDICAL PRO	FESSIONAL' S CERTIFICATI	ON
Complete the following if an interpreter was not used during ye pertaining to the examination(s) that form the basis of this Form		the applicant and medical professional
I am fluent in English and my examination(s) of this applicant.	, the language spoken by this patient.	Therefore, an interpreter was not used during
All medical professionals <b>must</b> complete the certification bel	low.	
I certify that this applicant's identity has been verified the identity document:	rough the following United States or Sta	ate government-issued photographic
Permanent Resident Card	☐ State ID Number: _	
Other Identification (State type and ID Number):		
I certify, under penalty of perjury under the laws of the Unite with it are all true and correct. I will furnish relevant medical I am aware that the knowing placement of false information of including under Title 18, U.S.C. Section 1546, civil penalties civil license suspension or revocation by the appropriate auth	records to USCIS, if requested to do so bon Form N-648 and related documents mas under Title 18, U.S.C. Section 247c of the	y USCIS, based on the applicant's consent. y also subject me to criminal penalties
Licensed Medical Professional Signature		Date (mm/dd/yyyy)

Applicant's Name			US	USCIS A-Number		
				=		
			•			
10	NTERPRET	ER'S CERTIFICATION				
An interpreter must complete, and certify, the section professional on the day of the examination that form		-	ns betw	veen the applican	t and medical	
Interpreter Information						
Last Name	First Name		Middle	Middle Name		
Address (Street Number and Name)	dress (Street Number and Name)  City			State or Province	Zip Code or Postal Code	
Was a phone interpreter used?  Yes (If yes, the interpreter is not required to complete the information below.)  No (If no, the interpreter is required to complete the information below.)  Interpreter Certification  I am fluent As the interpreter, I certify that I am fluent in English and the following language:  I further certify that I have accurately and completely translated all communications between the medical professional and the applicant that						
occurred on,	the date(s) of th	e examination(s) that form the bas	sis of th	is certification.		
Interpreter Signature  Date (mm/dd/yyyy)						
APPLICANT (PATIENT) ATTESTATION/RELEASE OF INFORMATION						
I,						
2 ac (min ac 333)						