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 Middle Name		USCIS A-Number A-		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 Osteopathy   Clinical Psychologist					
2. Medical practice type:					

Applicant's Name		USCIS A-Number A-
Part III. INFORM	ATION ABOUT DISABILITY and/or IMPAIRMENT(S)	
seeking an exception	liagnosis and DSM IV code ( <i>if applicable</i> ) of the applicant's disability and to the English and/or civics requirements; e.g., <i>DSM-IV 318.0 Down syno</i> nd explain why you cannot provide a DSM IV code.	
	ription of the disability and/or impairment(s), e.g., ''Down syndrome is a y (also referred to as mental retardation), developmental delays, and other	
3. Date von first examin	ned the applicant regarding the condition(s) listed in number 1.	
Date (mm/dd/yyyy)	Location (if different from business address on Page 1; otherwise write "same as bu	nsiness address")
4. Date you last examino	ed the applicant regarding the condition(s) listed in number 1, if differen	t from above.
Date (mm/dd/yyyy)	Location (if different from business address on Page 1; otherwise write "same as bu	isiness address")
5. Are you the medical p	professional regularly treating this applicant for the condition(s) listed in	Item Number 1?
Yes (If "Yes," inc	dicate duration of treatment.) Years Months	
	vide the name of the applicant's regularly treating medical professional on th tead of the regularly treating medical professional.)	e next page and explain why you are certifying

Applicant's Name	USCIS A-Number A-				
Name of Regularly Treating Medical Profession	al and Address.				
Last Name			Middle Name		
Business Address (Street Number and Name)	City State or Province		Zip Code or Postal Code	Telephone Number	
Explanation					
6. Has the applicant's disability and/or impairm	nent(s) lasted, or do you expect	it to last, 12 mon	ths or more?		
Yes (If "Yes,"continue to complete this for	m.)				
☐ No (If "No," the applicant is not eligible for the "Medical Professional's Certificati		ot complete the rei	nainder of the questions.	Please go directly to	
7. Is the applicant's disability and/or impairmen	nt(s) the result of the applicant	's illegal use of dı	rugs?		
Yes (If "Yes," the applicant is not eligible the "Medical Professional's Certification of the transfer of the		not complete the r	emainder of the question	s. Please go directly to	
☐ No (If "No," continue to complete this form	n.)				
8. What caused this applicant's medical disabil	ity and/or impairment(s) listed	l in number 1, if k	known?		

Applicant's Name	USCIS A-Number A-					
9. What clinical methods did you use to diagnose the applicant's medical disability and/or impair	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 him or her from demonstrating the following requirements? (Check all that apply. If none applies, the applicant is not eligible for this exception.)						
The ability to:						
Read English						
☐ Write English						
Speak English						
Answer questions regarding United States history and civics, even in a language the applicant und	derstands.					

Applicant's Name		USCIS A-Number A-
12. Was an interpreter used during your examination of t		
☐ Yes (If "Yes," the interpreter must complete the "In. ☐ No	terpreter Certification" section.)	
Additional Comments (Optional)		
MEDICAL PRO	OFESSIONAL' S CERTIFICATI	ON
Complete the following if an interpreter was not used during pertaining to the examination(s) that form the basis of this Fo		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 b	pelow.	
I certify that this applicant's identity has been verified tidentity document:	hrough 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 Uni with it are all true and correct. I will furnish relevant medic I am aware that the knowing placement of false information including under Title 18, U.S.C. Section 1546, civil penaltic civil license suspension or revocation by the appropriate au	al records to USCIS, if requested to do so b n on Form N-648 and related documents ma es under Title 18, U.S.C. Section 247c of th	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			U	JSCIS A-Number	
			A	<b>\</b> -	
I	NTERPRET	ER'S CERTIFICATION			
An interpreter must complete, and certify, the section professional on the day of the examination that form			ons betv	ween the applican	t and medical
Interpreter Information					
Last Name	First Name		Midd	lle Name	
Address (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.)  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 the examination(s) that form the basis of this certification.  Interpreter Signature  Date (mm/dd/yyyy)					
APPI ICANT (PATI	FNT) ATTE	STATION/RELEASE OF	TNE	ORMATION	
APPLICANT (PATIENT) ATTESTATION/RELEASE OF INFORMATION					
I,					
to release to U.S. Citizenship and Immigration Services all relevant physical and mental health information related to my medical status for the purpose of applying for an exception from the English language and U.S. civics requirements for naturalization. I certify under penalty of perjury, pursuant to Title 28, U.S.C. Section 1746, that the information I provided to the medical professional is true and correct. I am aware that the knowing placement of false information on Form N-648 and related documents may also subject me to civil penalties under Title 8, U.S.C. Section 1324c. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may not be found eligible for the requested disability exception.					
Applicant or Applicant's Authorized Representative Signature  Date (mm/dd/yyyy)					