

**I-601, Application for Waiver
of Ground of Excludability**

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| <input type="checkbox"/> 212 (a) (1) | <input type="checkbox"/> 212 (a) (10) |
| <input type="checkbox"/> 212 (a) (3) | <input type="checkbox"/> 212 (a) (12) |
| <input type="checkbox"/> 212 (a) (6) | <input type="checkbox"/> 212 (a) (19) |
| <input type="checkbox"/> 212 (a) (9) | <input type="checkbox"/> 212 (a) (23) |

A. Information about applicant

1. Family Name (Surname In CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State/Country) (Zip/Postal Code)

4. Date of Birth (mm/dd/yyyy) 5. CIS File Number
A-

6. City of Birth 7. Country of Birth

8. Date of Visa Application 9. Visa Applied for at:

B. Information about relative, through whom applicant claims eligibility for a waiver

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State) (Zip/Postal Code)

4. Relationship to applicant 5. DHS Status

**C. Information about applicant's other relatives in the United States
(List only U.S. citizens and permanent residents)**

1. Family Name (Surname in CAPS) (First) (Middle)

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10. Applicant was declared inadmissible to the United States for the following reasons: (List acts, convictions, or physical or mental conditions. If applicant has active or suspected tuberculosis, Page 2 of this fom must be fully completed.)

11. Applicant was previously in the United States, as follows:

City and State	From (Date)	To (Date)	DHS Status

12. Applicant's U.S. Social Security Number (if any)

Signature (of applicant or petitioning relative)

Relationship to applicant Date

Signature (of person preparing application, if not the applicant or petitioning relative). I declare that this document was prepared by me at the request of the applicant or petitioning relative, and is based on all information of which I have any knowledge.

Signature

Address Date

FOR CIS USE ONLY. DO NOT WRITE IN THIS AREA.

Initial receipt	Resubmitted	Relocated		Completed		
		Received	Sent	Approved	Denied	Returned

To Be Completed for Applicants With Active Tuberculosis or Suspected Tuberculosis

A. Statement by Applicant

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in Section B;
2. Present all X-rays used in the visa medical examination to substantiate diagnosis;
3. Submit to such examinations, treatment, isolation and medical regimen as may be required; and
4. Remain under the prescribed treatment or observation whether on inpatient or outpatient basis, until discharged.

Signature of Applicant

Date

B. Statement by Physician or Health Facility

(May be executed by a private physician, health department, other public or private health facility or military hospital.)

I agree to supply any treatment or observation necessary for the proper management of the alien's tuberculosis condition.

I agree to submit Form CDC 75.18, "Report on Alien with Tuberculosis Waiver," to the health officer named in Section D:

1. Within 30 days of the alien's reporting for care, indicating presumptive diagnosis, test results and plans for future care of the alien; or
2. 30 days after receiving Form CDC 75.18, if the alien has not reported.

Satisfactory financial arrangements have been made. (This statement does not relieve the alien from submitting evidence, as required by consul, to establish that the alien is not likely to become a public charge.)

I represent (enter an "X" in the appropriate box and give the complete name and address of the facility below.)

1. Local Health Department
 2. Other Public or Private Facility
 3. Private Practice
 4. Military Hospital

Name of Facility (Please type or print in black ink)

Address (Number and Street) (Room/Suite Number)

City, State and Zip Code

Signature of Physician

Date

C. Applicant's Sponsor in the United States

Arrange for medical care of the applicant and have the physician complete Section B.

If medical care will be provided by a physician who checked box 2 or 3, in Section B, have Section D completed by the local or State Health Officer who has jurisdiction in the United States area where the applicant plans to reside.

If medical care will be provided by a physician who checked box 4, in Section B, forward this form directly to the military facility at the address provided in Section B.

Address in the United States where the alien plans to reside.

Address (Number and Street) (Apartment Number)

City, State and Zip Code

D. Endorsement of Local or State Health Officer

Endorsement signifies recognition of the physician or facility for the purpose of providing care for tuberculosis. If the facility or physician who signed his or her name in Section B is not in your health jurisdiction and not familiar to you, you may want to contact the health officer responsible for the jurisdiction of the facility or physician prior to endorsing.

Endorsed by: Signature of Health Officer

Date

Enter below the name and address of the Local Health Department where the "Notice of Arrival of Alien with Tuberculosis Waiver" should be sent when the alien arrives in the United States.

Official Name of Department

Address (Number and Street) (Room/Suite Number)

City, State and Zip Code

If further assistance is needed, contact the CIS office with jurisdiction over the intended place of United States residence of the applicant.

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CIS Use Only: Additional Information and Instructions

Signature and Title of Requesting Officer

Address Date

This office will maintain only a folder relating to the applicant pursuant to A.M. 2712.01

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