Project Citizenship
4 Faneuil South Market Building
3rd Floor
Boston, MA 02109

Re: How to Complete Form N-648, Medical Certification for Disability Exceptions

Dear Medical Professional:

Please complete the attached form for a patient that you believe is unable to meet the English and/or civics requirements for naturalization due to a physical or development disability or mental impairment. If the patient does not have such a condition, please inform the patient that he or she does not qualify for the exception and do not complete the form. **Please note that illiteracy, educational attainment, and age alone are <u>not</u> qualifying conditions and should not be discussed in the form.**

- **Who may certify the form**: Only **<u>fully-licensed</u>** medical doctors, doctors of osteopathy, and clinical psychologists may certify the form. **Nurse practitioners and residents <u>cannot</u> certify the form,** but may assist in its completion. **The certifying medical professional <u>must</u> meet the patient prior to certifying the form**. An annotated form is attached to guide your completion of the blank form.

- **Waiving the Oath of Allegiance**: If you believe that a patient is unable to understand or communicate an understanding of the meaning of the Oath of Allegiance to the U.S., please provide an evaluation stating so **<u>in addition to the form</u>**. A template is attached.

- **Where to send the completed form**: Once you have completed the form (and evaluation, if applicable) please **<u>fax, email, or mail</u>** it to us. **The government strongly prefers original "wet signature" forms**.

- **Please note that we <u>cannot</u> schedule a patient for an appointment until we receive a sufficient form and/or evaluation.**

Part 1, Items 1-8
Enter all available information about the patient.

Part 2, Items 1-8
Enter your name, business address, and license information. The government **will check the license number** you provide to verify that you are a medical doctor, doctor of osteopathy, or clinical psychologist. **Nurse practitioners and residents cannot certify the form.**

Part 3, Item 1
Enter the clinical diagnosis of **only the most relevant conditions** that affect the patient's ability to read, write, and speak English, and/or demonstrate an understanding of civics. **You must enter a medical code for each condition.** For example, "ICD-10-CM F72 Severe intellectual disabilities." **Do not mention illiteracy, educational attainment, or age.**

Part 3, Item 2
Enter a basic description of **each** condition listed in Item 1. For example, "Intellectual Disability is a genetic disorder that causes lifelong disability…" **Do not discuss the patient specifically.**

Part 3, Items 3-4
Enter the date(s) when **each** condition listed in Item 1 began. Enter the date(s) of **each** diagnosis.

Part 3, Item 5
Enter the likely cause of **each** condition listed in Item 1. **If the cause of a condition is unknown, enter "Unknown."**

Part 3, Item 6
Enter the clinical methods you used to diagnose **each** condition listed in Item 1. For example, "I diagnosed the patient with dementia by using the Montreal Cognitive Assessment ("MoCA") test," or "I confirmed the diagnosis by reviewing the medical records provided by the patient." No specific techniques, tests, or methods are required. **Do not abbreviate test names.**

Part 3, Item 7
Describe the severity of **each** condition listed in Item 1 **as it relates to the patient**. For example, "Intellectual disability causes the patient to have very limited communication skills…"

Part 3, Item 8
Describe how **each** condition affects **specific functions of the patient's daily life** that are related to the ability to learn English and/or civics. Explain the basis of your assessment. For example, "Intellectual disability prevents the patient from obtaining regular employment."

Part 3, Items 9-10
Indicate whether **any** of the patient's conditions listed in Item 1 have lasted or are expected to last 12 months or more. **If the answer to this question is no, the patient does not qualify for the exception**. Explain which conditions listed in Item 1 are expected to last over 12 months and why.

Part 3, Items 11-12
Indicate whether **any** of the patient's conditions listed in Item 1 are the result of the patient's illegal use of drugs. **If the answer to this question is yes, the patient almost certainly does not qualify for the exception**.

Part 3, Item 13
Clearly describe how the patient's conditions affect the patient's ability to demonstrate knowledge and understanding of English and/or civics. **This is the most important part of the form. You must establish a clear and detailed causal connection between the patient's symptoms and inability to meet the requirements. The best answers to this question restate the patient's diagnosis and affirmatively state that due to the diagnosis the patient will be unable to meet the English and/or civics requirements, even in the patient's native language.** For example, "The patient suffers from dementia. Dementia causes the patient to be memory deficient. For example, the patient cannot remember family members' names. Because English and civics are new information for the patient, the patient will be unable to meet the English and civics requirements, even in the patient's native language."

Part 3, Item 14
Select **all** individual requirements you believe the patient should be exempt from (i.e., reading, speaking, or writing English, and/or answering civics questions, even in the patient's native language). **Your answer here must be consistent with your answer to Item 13.**

Part 3, Item 15
Enter the date and location you **first** examined the patient regarding the condition(s) listed in Item 1. **Do not write the date you first examined the patient regarding conditions not listed in the form.**

Part 3, Item 16
Enter the date and location you **last** examined the patient regarding the condition(s) listed in Item 1, if different from Item 15. **If not applicable, enter "N/A."**

Part 3, Item 17
Indicate whether you are the medical professional who regularly treats the patient for **any** condition listed in Item 1.

Part 3, Items 18-19
If you answered "Yes" to Item 17, indicate the duration of treatment and skip Items 20-22. Indicate the frequency of treatment.

Part 3, Items 20-22
If you answered "No" to Item 17, enter the regularly treating medical professional's name and contact information. **Explain why you are certifying the form instead**. For example, "The patient's regularly treating medical professional is a nurse practitioner who is not eligible to certify this form."

Part 3, Item 23
Indicate whether you used an interpreter when you examined the applicant. **If you used an interpreter, you must complete Part 4.** If you did not use an interpreter, proceed to Part 5.

Part 4, Items 1-5
Enter the interpreter's name and contact information

Part 4, Items 6-7
Ensure that the interpreter certifies that the interpreter is fluent in English and the language used during the exam(s), enters the exam date(s), and signs and dates the form. **If a telephonic interpreter was used, the interpreter does not need to complete these items.**

Part 4, Items 8-10
Indicate whether a telephonic interpreter was used during the exam(s). If a telephonic interpreter was used, indicate whether you asked the interpreter to affirm that the interpreter is fluent in the patient's language and would accurately and completely interpret all communications between you and the patient, and what the interpreter's answer was. **If a telephonic interpreter was not used, you do not need to complete Items 9-10.**

Part 5, Items 1-2
Ensure that the patient understands and fully completes the attestation.

Part 6, Item 1
If you did not use an interpreter during the exam(s), indicate whether you are fluent in the patient's language or whether the patient speaks English.

Part 6, Item 2
Indicate which form of government-issued photo ID you used to verify the patient's identity.

Part 6, Item 3
Sign and date the form.

If you have any questions or concerns about completing the form, please do not hesitate to contact our office at (617) 694-5949 or info@projectcitizenship.org. It is a very challenging form to complete and we are happy to work with you to revise it in order to ensure the best possible outcome for your patient and our client.

Thank you,

Project Citizenship

N-648s cannot be completed by a representative for doctor's signature, It may be completed by the doctor's staff but the doctor must sign it and is responsihle for its accuracy.

You can complete this form online at the link below to make it easier to read

Medical Certification for Disability Exceptions

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

USCIS
Form N-648
OMB No. 1615-0069
Expires 12/31/2021

https://www.uscis.gov/n-648 T

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

Please read the instructions before examining the applicant and filling out this form.

Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of the Commonwealth of the Northern Mariana Islands (CNMI), 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. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.

If you are using an interpreter during the examination (either in person or by phone), you must ask the interpreter the following questions and affirm their response:

- Do you certify that you are fluent in English and the following language, _____
- Do you further certify that you will accurately and completely interpret all communications between the applicant _____ and me (the medical professional)?

Waiver requests are reviewed by USCIS officers, not by trained medical professionals.

Part 1. Applicant Information

USPS ZIP Code Lookup

In part 1, enter as much information as possible about the patient.

I certify that I have examined the following applicant.

1. Applicant's Legal Name

Family Name (Last Name) | Given Name (First Name)

Middle Name (if any)

2. Applicant's Current Physical Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

USCIS USE ONLY

This N-648 is:
- ☐ Sufficient
- ☐ Insufficient
- ☐ Continued/RFE

Reviewer

Location & Date

Applicant's Other Information

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

4. U.S. Social Security Number (if any)
►

5. Date of Birth (mm/dd/yyyy)

6. Gender
☐ Male ☐ Female

7. Applicant's Telephone Number

8. Applicant's Email Address (if any)

Part 2. Medical Professional Information

1. Medical Professional's Name

Nurse practitioners and residents cannot certify this form.

Family Name (Last Name) | Given Name (First Name) | Middle Name (if any)

2. Medical Professional's Business Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

3. License Number

4. Licensing State

5. Business Telephone Number

6. Email Address (if any)

7. I am currently licensed as a (select all that apply):

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Clinical Psychologist

8. Medical Practice Type:

Part 3. Information About Disabilities and/or Impairments

1. Provide the clinical diagnosis of **all** physical or developmental disabilities and/or mental impairments that may affect the applicant's ability to demonstrate an understanding of the English language and/or a knowledge and understanding of the fundamentals of the history and the principles and form of government of the United States. If applicable, please provide the relevant medical code as accepted by the Department of Health and Human Services (HHS). This includes the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). For example, "DSM-V 318.1 Intellectual Disability (Severe)" or "2015/16 ICD-10-CM F72 Severe intellectual disabilities."

Be sure to include the ICD-10 or DSM-V Code!

Words like "illiterate" or "uneducated" or references to age are red flags to USCIS and may cause the form to be denied, regardless of the patient's other diagnoses.

Please make sure you are using the form dated 07/23/20

Part 3. Information About Disabilities and/or Impairments (continued)

2. Provide a basic description of all the disabilities and/or impairments listed in **Part 3**, **Item 1**. For example, "Intellectual Disability (Severe) is a genetic disorder that causes lifelong intellectual disability, developmental delays, and other problems."

The description must be basic and general. You should define the condition for a non-medical audience. Avoid description that is specific to the patient.

3. When did each disability or impairment listed in **Part 3.**, **Item Number 1.**, begin?

Date (mm/dd/yyyy) _____ If you need extra space to complete this section, use the space provided below.

If there are multiple diagnoses, please use this space to list all of them and when the disability or impairment began. If the patient has had it since birth, please indicate that.

4. Date(s) of Diagnosis (mm/dd/yyyy) _____ _____

If you need extra space to complete this section, use the space provided below.

If there are multiple diagnoses, please use this space to list all of them and when the disability or impairment was diagnosed.

5. What caused each of this applicant's medical disabilities and/or impairments listed in **Part 3.**, **Item Number 1.**, if known?

If the cause is not known, you should write "unknown."

Part 3. Information About Disabilities and/or Impairments (continued)

6. What clinical methods did you use to diagnose each of the applicant's medical disabilities and/or impairment(s) listed in **Part 3.**, **Item Number 1.**?

No specific tests are required for this section, but you must give a thorough explanation. You should describe the test(s), lay out the patient's results, and explain what those results mean and why they lead you to the diagnosis. You should use common language in describing the tests and results. Do NOT abbreviate test names.

One quick test that USCIS will accept for mental capacity is the Mini Mental State Examination. See minimental.com for more information.

7. Describe the severity of each disability and/or impairment listed in **Part 3.**, **Item Number 1.** Explain the basis of your assessment, i.e. known symptoms of condition, tests conducted, observations, etc.

Describe the severity of each condition in reference to the patient's specific case. Indicate the severity of each diagnosis named in Part 3, Question 1.

8. Describe how each relevant disability and/or impairment affects specific functions of the applicant's daily life, including the ability to work or go to school, that may be related to the ability to learn civics and/or English, including the ability to read, write and speak words in ordinary usage of the English language. Explain the basis of your assessment, including known symptoms of condition, tests conducted, observations, etc.

Describe how each impairment or disability diagnosed affects specific functions of the patient's daily life that relate to the English and civics requirements. This section should be patient specific.

9. Have any of the applicant's disabilities and/or impairments lasted, or do you expect any of them to last, 12 months or more?

☐ Yes ☐ No

Disability or impairment must have lasted or be expected to last 12 months or more. Applicants who can pass with reasonable accommodations do not qualify.

Part 3. Information About Disabilities and/or Impairments (continued)

10. Provide an explanation as to which disabilities or impairments are expected to last over 12 months and why.

NOTE: If you answered "No," the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

11. Are any of the disabilities and/or impairment(s) the result of the applicant's illegal use of drugs?

☐ Yes ☐ No

12. If yes, provide an explanation as to which disabilities or impairments are the result of the applicant's illegal use of drugs.

NOTE: If you answered "Yes" and all of the applicant's disabilities and/or impairments are the result of the applicant's illegal use of drugs, the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

13. Clearly describe how each of the applicant's disabilities and/or impairments affects his or her ability to demonstrate knowledge and understanding of English and/or civics.

This is the most important question on the form. The causation is critical! USCIS will not approve the waiver without this explanation. You should:
1) Restate the disability and the symptoms.
2) Explain how the symptoms make it impossible to learn new information.
3) Affirmatively state the applicant is unable to take the test.

If the patient's impairment would not prevent them from learning English or Civics, do NOT fill out this form.

You can also use this space to discuss the applicant's medication(s) and how that/ those medication(s) affect the applicant's impairment.

14. In your professional medical opinion, do any of the applicant's disabilities or impairments prevent him or her from demonstrating the following requirements? (Select all that apply. If none applies, the applicant is not eligible for this exception.)

The ability to: ☐ Read English ☐ Speak English ☐ Write English

☐ Answer questions regarding United States history and civics, even in a language the applicant understands.

15. Date and location you first examined the applicant regarding the condition(s) listed in **Part 3.**, **Item Number 1.**

A. Date (mm/dd/yyyy) ☐

Part 3. Information About Disabilities and/or Impairments (continued)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

16. Date and location you last examined the applicant regarding the conditions listed in **Part 3.**, **Item Number 1.**, if different from above.

A. Date (mm/dd/yyyy)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

17. Are you the medical professional who regularly treats this applicant for the conditions listed in **Part 3.**, **Item Number 1.**?

☐ Yes ☐ No

18. If you answered "Yes," indicate the duration of treatment and skip **Item Number 20. - 22.**

Years Months

19. Please indicate the frequency of treatment.

☐ Weekly ☐ Monthly ☐ Yearly ☐ Other

20. Name of Regularly Treating Medical Professional

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

21. Business Address and Phone Number of Regularly Treating Medical Professional

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

City or Town | State | ZIP Code

Province | Postal Code | Country

Part 3. Information About Disabilities and/or Impairments (continued)

22. Explanation for why you are certifying this form instead of the regularly treating medical professional.

If you are not the regularly treating medical professional, you must explain why you are the medical professional completing the form.

23. Did you use an interpreter when you examined the applicant?

☐ Yes ☐ No

NOTE: If you answered "Yes," the interpreter must complete **Part 4. Interpreter's Certification**. If you used a telephonic interpreter, please complete all **Items** in **Part 4. except Item Numbers 6.** and **7.**

Additional Comments (Optional)

Part 4. Interpreter's Certification

The interpreter must complete and certify the section below if an interpreter interpreted communications between the applicant and medical professional on the day of the examination that formed the basis of this Form N-648.

1. Interpreter's Name

Interpreters, including family members and phone interpreters, must be listed.

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

2. Interpreter's Mailing Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

4. Interpreter's Mobile Telephone Number (if any)

5. Interpreter's Email Address (if any)

Part 4. Interpreter's Certification (continued)

Interpreter's Certification

6. I certify that I am fluent in English and the following language, _____. I further certify that I have accurately and completely interpreted all communications between the medical professional and the applicant that occurred on _____, the dates of the examinations that form the basis of this certification.

7. Interpreter's Signature _____ Date of Signature (mm/dd/yyyy) _____

Don't forget to have the interpreter sign!

Certification for Telephonic Interpreter (to be completed by the medical professional)

8. Was a telephonic interpreter used during the examination of the applicant?

☐ Yes (go to question 9.) ☐ No

9. If you answered yes, did you ask the interpreter to affirm that he or she speaks fluent English and the applicant's language and that he or she will accurately and completely interpret all communications between you and the applicant?

☐ Yes ☐ No

10. If yes, did the interpreter answer in the affirmative?

☐ Yes ☐ No

If phone interpreter is used, no signature is required but please include the name of the interpreter service used, the interpreter ID, and as much information about the interpreter as possible.

Part 5. Applicant's (Patient's) Attestation/Release of Information

1. I, _____ (Applicant's Name), authorize _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) 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 28 U.S.C. section 1746, that the information I provided to the medical professional is true and correct. I certify under penalty of perjury, pursuant to 28 U.S.C. section 1746, that I have attended an appointment with _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) and was then diagnosed by him or her. 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 8 U.S.C. section 1324c and INA section 274C. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may be found ineligible for the requested disability exception.

2. Applicant or Applicant's Authorized Representative's Signature _____ Date of Signature (mm/dd/yyyy) _____

Please have the patient sign here.

Part 6. Medical Professional's Certification

Complete the following if you did not use an interpreter to communicate with the applicant during the examinations that form the basis of this Form N-648.

1. I did not use an interpreter during my examinations of this applicant because:

☐ I am fluent in English and _____, the language spoken by this applicant.

☐ This applicant speaks English.

Part 6. Medical Professional's Certification (continued)

All medical professionals **must** complete the certification below.

2. I certify that this applicant's identity has been verified through the following United States or State government-issued photographic identity document:

☐ Permanent Resident Card ☐ State ID Number:

☐ Other Identification (Indicate type and ID Number):

I certify, under penalty of perjury under the laws of the United States of America, that the information on this form and any evidence submitted with it are all true and correct. I will furnish relevant medical records to USCIS, if requested to do so by USCIS, based on the applicant's consent. I am aware that the knowing placement of false information on Form N-648 and related documents may also subject me to criminal penalties including under 18 U.S.C. section 1546, civil penalties under 8 U.S.C. section 1324c and Immigration and Nationality Act (INA) section 274C, and civil license suspension or revocation by the appropriate authorities.

3. Licensed Medical Professional Signature

Don't forget to sign!

Date of Signature (mm/dd/yyyy)

Date on N-648 must be within 6 months of the date the N-400 is submitted.

Medical Certification for Disability Exceptions

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

USCIS
Form N-648
OMB No. 1615-0069
Expires 12/31/2021

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

Please read the instructions before examining the applicant and filling out this form.

Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of the Commonwealth of the Northern Mariana Islands (CNMI), 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. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.

If you are using an interpreter during the examination (either in person or by phone), you must ask the interpreter the following questions and affirm their response:

- Do you certify that you are fluent in English and the following language, _____ ,
- Do you further certify that you will accurately and completely interpret all communications between the applicant _____ and me (the medical professional)?

Part 1. Applicant Information

USPS ZIP Code Lookup

I certify that I have examined the following applicant.

1. Applicant's Legal Name

Family Name (Last Name)

Given Name (First Name)

Middle Name (if any)

2. Applicant's Current Physical Address

Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Province

Postal Code

Country

USCIS USE ONLY

This N-648 is:

- ☐ Sufficient
- ☐ Insufficient
- ☐ Continued/RFE

Reviewer

Location & Date

Applicant's Other Information

3. Alien Registration Number (A-Number) (if any)

► **A-**

4. U.S. Social Security Number (if any)

►

5. Date of Birth (mm/dd/yyyy)

6. Gender

☐ Male ☐ Female

7. Applicant's Telephone Number

8. Applicant's Email Address (if any)

Part 2. Medical Professional Information

1. Medical Professional's Name

Family Name (Last Name) | Given Name (First Name) | Middle Name (if any)

2. Medical Professional's Business Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

3. License Number

4. Licensing State

5. Business Telephone Number

6. Email Address (if any)

7. I am currently licensed as a (select all that apply):

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Clinical Psychologist

8. Medical Practice Type:

Part 3. Information About Disabilities and/or Impairments

1. Provide the clinical diagnosis of **all** physical or developmental disabilities and/or mental impairments that may affect the applicant's ability to demonstrate an understanding of the English language and/or a knowledge and understanding of the fundamentals of the history and the principles and form of government of the United States. If applicable, please provide the relevant medical code as accepted by the Department of Health and Human Services (HHS). This includes the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). For example, "DSM-V 318.1 Intellectual Disability (Severe)" or "2015/16 ICD-10-CM F72 Severe intellectual disabilities."

Part 3. Information About Disabilities and/or Impairments (continued)

2. Provide a basic description of all the disabilities and/or impairments listed in **Part 3**, **Item 1**. For example, "Intellectual Disability (Severe) is a genetic disorder that causes lifelong intellectual disability, developmental delays, and other problems."

3. When did each disability or impairment listed in **Part 3.**, **Item Number 1.**, begin?

Date (mm/dd/yyyy) If you need extra space to complete this section, use the space provided below.

4. Date(s) of Diagnosis (mm/dd/yyyy)

If you need extra space to complete this section, use the space provided below.

5. What caused each of this applicant's medical disabilities and/or impairments listed in **Part 3.**, **Item Number 1.**, if known?

Part 3. Information About Disabilities and/or Impairments (continued)

6. What clinical methods did you use to diagnose each of the applicant's medical disabilities and/or impairment(s) listed in **Part 3.**, **Item Number 1.**?

7. Describe the severity of each disability and/or impairment listed in **Part 3.**, **Item Number 1.** Explain the basis of your assessment, i.e. known symptoms of condition, tests conducted, observations, etc.

8. Describe how each relevant disability and/or impairment affects specific functions of the applicant's daily life, including the ability to work or go to school, that may be related to the ability to learn civics and/or English, including the ability to read, write and speak words in ordinary usage of the English language. Explain the basis of your assessment, including known symptoms of condition, tests conducted, observations, etc.

9. Have any of the applicant's disabilities and/or impairments lasted, or do you expect any of them to last, 12 months or more?

☐ Yes ☐ No

Part 3. Information About Disabilities and/or Impairments (continued)

10. Provide an explanation as to which disabilities or impairments are expected to last over 12 months and why.

NOTE: If you answered "No," the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

11. Are any of the disabilities and/or impairment(s) the result of the applicant's illegal use of drugs?

☐ Yes ☐ No

12. If yes, provide an explanation as to which disabilities or impairments are the result of the applicant's illegal use of drugs.

NOTE: If you answered "Yes" and all of the applicant's disabilities and/or impairments are the result of the applicant's illegal use of drugs, the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

13. Clearly describe how each of the applicant's disabilities and/or impairments affects his or her ability to demonstrate knowledge and understanding of English and/or civics.

14. In your professional medical opinion, do any of the applicant's disabilities or impairments prevent him or her from demonstrating the following requirements? (Select all that apply. If none applies, the applicant is not eligible for this exception.)

The ability to: ☐ Read English ☐ Speak English ☐ Write English

☐ Answer questions regarding United States history and civics, even in a language the applicant understands.

15. Date and location you first examined the applicant regarding the condition(s) listed in **Part 3.**, **Item Number 1.**

A. Date (mm/dd/yyyy)

Part 3. Information About Disabilities and/or Impairments (continued)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

16. Date and location you last examined the applicant regarding the conditions listed in **Part 3.**, **Item Number 1.**, if different from above.

A. Date (mm/dd/yyyy)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

17. Are you the medical professional who regularly treats this applicant for the conditions listed in **Part 3.**, **Item Number 1.**?

☐ Yes ☐ No

18. If you answered "Yes," indicate the duration of treatment and skip **Item Number 20. - 22.**

Years Months

19. Please indicate the frequency of treatment.

☐ Weekly ☐ Monthly ☐ Yearly ☐ Other

20. Name of Regularly Treating Medical Professional

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

21. Business Address and Phone Number of Regularly Treating Medical Professional

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

City or Town | State | ZIP Code

Province | Postal Code | Country

Part 3. Information About Disabilities and/or Impairments (continued)

22. Explanation for why you are certifying this form instead of the regularly treating medical professional.

23. Did you use an interpreter when you examined the applicant?

☐ Yes ☐ No

NOTE: If you answered "Yes," the interpreter must complete **Part 4. Interpreter's Certification**. If you used a telephonic interpreter, please complete all **Items** in **Part 4. except Item Numbers 6.** and **7.**

Additional Comments (Optional)

Part 4. Interpreter's Certification

The interpreter must complete and certify the section below if an interpreter interpreted communications between the applicant and medical professional on the day of the examination that formed the basis of this Form N-648.

1. Interpreter's Name

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

2. Interpreter's Mailing Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

4. Interpreter's Mobile Telephone Number (if any)

5. Interpreter's Email Address (if any)

Part 4. Interpreter's Certification (continued)

Interpreter's Certification

6. I certify that I am fluent in English and the following language, [ ]. I further certify that I have accurately and completely interpreted all communications between the medical professional and the applicant that occurred on [ ], the dates of the examinations that form the basis of this certification.

7. Interpreter's Signature [ ] Date of Signature (mm/dd/yyyy) [ ]

Certification for Telephonic Interpreter (to be completed by the medical professional)

8. Was a telephonic interpreter used during the examination of the applicant?

☐ Yes (go to question 9.) ☐ No

9. If you answered yes, did you ask the interpreter to affirm that he or she speaks fluent English and the applicant's language and that he or she will accurately and completely interpret all communications between you and the applicant?

☐ Yes ☐ No

10. If yes, did the interpreter answer in the affirmative?

☐ Yes ☐ No

Part 5. Applicant's (Patient's) Attestation/Release of Information

1. I, _____ (Applicant's Name), authorize _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) 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 28 U.S.C. section 1746, that the information I provided to the medical professional is true and correct. I certify under penalty of perjury, pursuant to 28 U.S.C. section 1746, that I have attended an appointment with _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) and was then diagnosed by him or her. 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 8 U.S.C. section 1324c and INA section 274C. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may be found ineligible for the requested disability exception.

2. Applicant or Applicant's Authorized Representative's Signature [ ] Date of Signature (mm/dd/yyyy) [ ]

Part 6. Medical Professional's Certification

Complete the following if you did not use an interpreter to communicate with the applicant during the examinations that form the basis of this Form N-648.

1. I did not use an interpreter during my examinations of this applicant because:

☐ I am fluent in English and [ ], the language spoken by this applicant.

☐ This applicant speaks English.

Part 6. Medical Professional's Certification (continued)

All medical professionals **must** complete the certification below.

2. I certify that this applicant's identity has been verified through the following United States or State government-issued photographic identity document:

☐ Permanent Resident Card ☐ State ID Number: _____

☐ Other Identification (Indicate type and ID Number): _____

I certify, under penalty of perjury under the laws of the United States of America, that the information on this form and any evidence submitted with it are all true and correct. I will furnish relevant medical records to USCIS, if requested to do so by USCIS, based on the applicant's consent. I am aware that the knowing placement of false information on Form N-648 and related documents may also subject me to criminal penalties including under 18 U.S.C. section 1546, civil penalties under 8 U.S.C. section 1324c and Immigration and Nationality Act (INA) section 274C, and civil license suspension or revocation by the appropriate authorities.

3. Licensed Medical Professional Signature _____ Date of Signature (mm/dd/yyyy) _____

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

Re:
N-400, Application for Naturalization

EVALUATION TO TAKE THE OATH OF ALLEGIANCE

Dear USCIS:

In accordance with the USCIS Policy Manual and 8 C.F.R. § 316.12, I am providing this evaluation regarding the above applicant's ability to take the Oath of Allegiance.[1]

The applicant has been my patient since:

-

The applicant has the following condition(s) which affect the applicant's ability to understand or communicate an understanding of the oath:

-

The condition(s) are characterized by the following symptom(s):

-

Considering the applicant's symptoms, it is my medical opinion that the applicant is:

(●) unable to understand or communicate an understanding of the meaning of the oath and is not expected to be able to do so in the near future.

( ) able to understand or communicate an understanding of the oath and fully understands the purpose and responsibilities of the naturalization procedures.

Sincerely,

_____
Medical Professional Signature

_____
License Number

[1] *See* 12 USCIS-PM J.3(C), https://www.uscis.gov/policy-manual/volume-12-part-j-chapter-3; 8 C.F.R. § 316.12.