OMB No. 1615-0032; Expires 11/30/2014

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

Form I-690, Application for Waiver of Grounds of Inadmissibility

For Government Use Only.

Fee Receipt Number (This application):	Fee Stamp
Alien Registration Number (A# of This Applicant):	

APPLICANT: Start here. See instructions before completing this application. If you need more space to answer fully any question on this form, use a separate sheet and identify each answer with the number of the corresponding question. Type or print in black ink.

1. Family Name *(Last Name in CAPITAL letters)* *(First Name)* *(Middle Name)*

2. Date of Birth *(mm/dd/yyyy)*

3. Address *(No. and Street)* *(Apt. No.)* *(City/Town)* *(State/Country)* *(Zip/Postal Code)*

4. Place of Birth *(City or Town and County, Province or State)* *(Country)*

5. U.S. Social Security Number

6. Date of Visa Application *(mm/dd/yyyy)* **for:**
☐ Permanent Residence
☐ Temporary Residence

7. Visa applied for at:

8. I am applying for a waiver of:
☐ 212 (a) (1)(A)(i), (ii), (iii) or (iv)
☐ 212 (a)(2)(C)(i)(II) - possession of marijuana, 30 gms or less
☐ 212 (a)(6)(A)(i)
☐ 212(a)(6)(C)(i) or (ii)
☐ 212(a)(6)(D) and/or (E)
☐ 212(a)(8)(A) and/or (B)
☐ 212(a)(9)(A)(i) or (ii)
☐ 212(a)(9)(B)(i)(I) or (i)(II)
☐ 212(a)(9)(C)(i)(I) or (i)(II)
☐ 212 (a)(10)(A), (B), (C), (D) and/or (E) - Please specify:

9. List reasons of inadmissibility:

10. List all immediate relatives in the United States (*Parents, spouse and children):*

Name	Address	Relationship	Immigration Status

11. I should be granted a waiver because: *(Describe family unity considerations or humanitarian or public interest reasons for granting a waiver. If more space is needed, attach an additional sheet.)*

12. Applicant's Signature

13. Date

FOR USCIS USE ONLY. Recommended by:

(Print Name and Title) _____ Date _____

Signature _____ *Stamp #* _____ Director _____

Supplement for Applicants With Tuberculosis (TB)

Part A. Applicant's Sponsor in the United States.

1. Make arrangements for the applicant's medical care and have the attending physician or facility complete **Part C**.

2. Obtain the necessary endorsements.

a. Treatment is being provided by a state or local health department: If a state or local health department will provide the necessary care and/or treatment to the applicant, that facility should check block (a) in Number 4 under **Part C**. The health department is not required to complete anything else on this form.

b. Treatment is being provided by a private physician or by any other private or public facility: If a private physician, a private medical facility or a public medical facility (other than a state or local health department) will provide the applicant's medical care and/or treatment, that facility should check block (b) or (c) under Number 4 of **Part C**, as applicable. In that case, the state or local health department in the jurisdiction where the applicant will reside must complete **Part D**.

3. Address in the United States where the applicant plans to reside:

Address *(Number and Street)* *(Apartment No.)*

City, State and Zip Code

Part B. Applicant's Statement:

Upon admission to the United States, I will:

1. Go directly to the physician or health facility named in Number 5 of **Part C**;

2. Present copies of diagnostic tests used on the visa examination to substantiate diagnosis;

3. Submit to counseling and such examinations, treatment and medical regimen as may be required; and

4. Remain under prescribed treatment or observation whether on inpatient or outpatient basis, until discharged.

Part *C. Statement by Physician or Health Facility:*

1. I agree to supply counseling and any treatment or observation necessary for the proper management of the applicant's condition.

2. I agree to submit a copy of my evaluation to the Division of Global Migration and Quarantine (E03), Centers for Disease Control and Prevention, Atlanta, Georgia 30333, and certify the following:

a. I will submit a copy of my evaluation within 30 days of the date the applicant is required to appear for evaluation and/or care; and

b. If at the end of the 30-day period the applicant fails to appear for evaluation and/or care as required, I will submit a report to that effect to the CDC.

3. Satisfactory financial arrangements have been made for the applicant's medical care and treatment. (This statement does not relieve the applicant from submitting evidence, as required by the consular officer or USCIS, to establish that he or she is not likely to become a public charge (another ground of inadmissibility under section 212(a)(4) of the Immigration and Nationality Act).

4. I represent: *(Check the appropriate box and provide the information requested below.)*

a. ☐ Local Health Department

b. ☐ Other Public Health Facility

c. ☐ Private Medical Practice

5. ☐ I agree to submit a copy of my evaluation to the health officer indicated in **Part D**. *(Required if you checked block (b) or (c) in Number 4 directly above.)*

Name of Physician or Facility *(Please type or print)*

Address *(Number and Street)*

City, State and Zip Code

Signature of Physician Date

Part 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 physician who signed in **Part C** is not in your health jurisdiction or is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction, and/or the physician, before you sign this endorsement.

Official Name of Department *(Please type or print.)*

Signature Date

Name of Health Department to receive the required notice from the CDC following the Applicant's arrival in the United States/adjustment of status. *(Please type or print.)*

Address *(Number and Street)*

City, State and Zip Code