OMB No. 1615-0029; Expires 02/29/08

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

I-601, Application for Waiver of Grounds of Inadmissibility

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☐ 212 (a) (1)
☐ 212 (a) (2)
☐ 212 (a) (3)
☐ 212 (a) (6)
☐ 212 (a) (9)

Fee Stamp

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)

Telephone Number E-Mail Address

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

6. City/Province-State of Birth

7a. Country of Birth **7b.** Country of Citizenship/Nationality

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

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 3** of this form must be fully completed. If applicant has HIV infection, Page 3 of this form must be fully completed.)

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

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

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

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)

Telephone Number E-Mail Address

4. Relationship to Applicant **5.** Immigration Status

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Initial receipt	Resubmitted	Relocated		Completed		
		Received	Sent	Approved	Denied	Returned

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)

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

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

4. Relationship to Applicant **5**. Immigration Status

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**. Immigration Status

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**. Immigration Status

CERTIFICATION: Signature (of applicant or petitioning relative)

Relationship to Applicant Date

PREPARER OF APPLICATION: 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

To Be Completed for Applicants With Active Tuberculosis or Suspected Tuberculosis

A. Statement by Applicant.

Upon admission to the United States I will:

- Go directly to the physician or health facility named in **Section B**;
- Present all X-rays used in the visa medical examination to substantiate diagnosis;
- Submit to such examinations, treatment, isolation and medical regimen as may be required; and
- 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**:

- Within 30 days of the alien's reporting for care, indicating presumptive diagnosis, test results and plans for future care of the alien; or
- 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) (Apt #)

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

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

To Be Completed for Applicants With Human Immunodeficiency Virus (HIV) Infection

A. Statement about applicant.

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in **Section B**;
2. Present copies of diagnostic tests used in 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.

Signature of Applicant

_____

Date _____

B. Statement by Physician or Health Facility

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

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

I agree to submit a copy of my evaluation of the alien's condition to the health officer named in Section D and to the Division of Quarentine (E03), Centers for Disease Control and Prevention (CDC), Atlanta Georgia 30333:

1. Within 30 days of the alien's reporting for care indicating plans for future care of the alien; or
2. A report that the alien has not reported within 30 days after receiving a notice from the Division of Quarantine, CDC.

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 Physician or Facility (Please type or print)

_____

Address (Number & Street)

_____

City, State, & Zip Code

_____

Signature of Physician

_____

Date

C. Applicant's Sponsor in the U.S.

Arrange for medical care of the applicant and have the physician of facility 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 area where the applicant plans to reside in the U.S.

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 where the alien plans to reside in the U.S.:

_____

Address (Number & Street) **APT No.**

_____

City, State, & 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 HIV infection. If the facility or physician who signed in Section B is not in your health jurisdiction and is not familiar to you, you may wish 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 to which the "Notice of Arrival of Alien with HIV infection Waiver" should be sent when the alien arrives in the U.S.

Official Name of Department

_____

Address (Number & Street) **APT No.**

_____

City, State, & Zip Code

_____

Please read instructions with care.

If further assistance is needed, contact the USCIS office with jurisdiction over the intended place of U.S. residence of the applicant.

NOTE: If you are approved for a waiver and after admission to the U.S. you fail to comply with the terms, conditions, and controls that were imposed, you may be subject to removal under Section 237 (a) of the Immigration and Nationality Act.

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

4. Relationship to Applicant **5**. Immigration Status

USCIS 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