OMB No. 1615-0086; Expires 06/30/09

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

# I-905, Application for Authorization to Issue Certification for Health Care Workers

**START HERE - Please type or print in black ink.**

## Part 1. Information about the applicant filing this form.

Company or Organization

**Address**

Street Number and Name | Room #

City | State | Zip/Postal Code

IRS Tax # | Name of Point of Contact

Phone # of Point of Contact ( ) | Title of Point of Contact

**Date organization was created.**

**Description of your organization.**

**Occupations for which you are seeking authorization.**

**Describe the process you will use to issue certificates** *(If more space is required, use a separate sheet(s) of paper).*

**Explain your organization's expertise, knowledge and experience in the health care occupations for which you are seeking authorization.**

## For USCIS Use Only

| Returned | Receipt |
|---|---|
| Resubmitted | |
| Reloc Sent | |
| Reloc Rec'd | |

☐ Approved for all requested occupations.

☐ Partial approval (USCIS must list approved occupations.)

**Action Block**

**To Be Completed by**
***Attorney or Representative, if any***

☐ Fill in box if G-28 is attached to represent the petitioner

VOLAG#

ATTY State License #

**Explain how your organization meets the standards described in the instructions sheet.** *(If more space is required, attach a separate sheet(s) of paper).*

**Describe the procedure you will establish for U.S. Citizenship and Immigration Services to use to verify the validity of your certificates.**

## Part 2. Signature. *Read the information on penalties in the instructions before completing this section.*

I certify, under penalty of perjury under the laws of the United States of America, that this application and the evidence submitted with it are all true and correct. If filing this on behalf of an organization, I certify that I am empowered to do so by that organization. I authorize the release of any information from my records or from the applicant's organization's records that U.S. Citizenship and Immigration Services needs to determine eligibility for the benefit I am seeking. If this application is approved, I also agree to provide U.S. Citizenship and Immigration Services with any information that it requests to determine the organization's eligibility to continue to issue certificates to health care workers.

| Signature and Title | Print Name | Date |
|---|---|---|
| | | |

**NOTE:** *If you do not completely fill out this form or fail to submit required documents listed in the instructions, this application may be denied.*

## Part 3. Signature of person preparing form, if other than above. (Sign below.)

I declare that I prepared this application at the request of the above person and it is based on all information of which I have knowledge.

| **Signature** | Print Name | Date |
|---|---|---|
| | | |

| Firm Name and Address (Street Number and Name; Suite/Room Number; City/Town; State; Zip Code | Daytime Telephone Number *(Area Code and Number)* ( ) | Fax Number *(Area Code and Number)* ( ) |
|---|---|---|
| | E-Mail Address *(If any)* | |