Champlain Medical – Immigration Exam Information

Address: 150 Kennedy Drive, S. Burlington, VT, 05403
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Email: i693@champlainmedical.com
Website: www.champlainmedical.com/

Hours: Monday-Friday, 8 AM – 4 PM

Dear Applicant,

This letter provides important information for those who need to complete the **I-693 Immigration Medical Exam** at Champlain Medical. This exam must be done by a **Civil Surgeon** (a doctor approved for immigration exams). Please read this carefully to understand the process.

Cost & Payment

The total cost for the exam is **$220 per person.** This includes:

- Medical exam
- Vaccine review
- Mailing of the form or in-office pickup
- This **does not include lab tests** which are required and extra cost. (see below)

We **do not accept insurance** for this fee. If you need additional tests or vaccines, there may be extra charges.

Cancellation Policy: If you cancel within **48 hours** of your appointment, you will still be charged **$220**.

Required Tests (Extra Charges Apply)

Some tests are required based on your age. These must be done at your appointment:

1. **Tuberculosis (TB) Test** (required for ages **2 and older**)
    - Blood test (IGRA) → **$85**
    - If positive, a **chest X-ray** will be needed (extra cost)
2. **Syphilis Test** (required for ages **18-44**
    - Blood test → **$20**
3. **Gonorrhea Test** (required for ages **18-24;**
    - Urine test → **$20**

If any test is positive, you must get treatment before we can complete your I-693 form. We charge an additional $25 for our staff to draw your blood.

Steps Before Scheduling Your Appointment

Before booking your exam, please email these documents to **i693@champlainmedical.com:**

1. **Page 1 & 2 of the I-693 Form**
2. **Champlain Medical's Review Form**
3. **Patient acknowledgement form**
4. **Vaccine records** (including childhood vaccines)
5. **Tuberculosis (TB) records** (if you had TB in the past)
6. **Other relevant medical records**, such as prior vaccine titers

Once we receive your documents, we will send you an email with instructions on how to book your appointment. We will also note **vaccinations you will need prior to the examination day. Please wait 2 business days before calling us.**

Important Appointment Information

- Bring a **valid photo ID (passport or government-issued ID)**
- Bring **copies of your vaccine and medical records**
- **Arrive at least 15 minutes early**

If you **do not speak English**, you **must bring an interpreter** with you.

Vaccine Requirements

You must be up to date with all required vaccines. **We recommend getting vaccines before your appointment. These can NOT be given during your visit for your exam.** You can:

- **Get vaccines at a pharmacy**
- **Get vaccines from your doctor**
- **Get vaccines from us ($20 per vaccine, Flu shot $32)**

You can also submit **blood test results (titers)** to show immunity to **varicella, hepatitis B, and MMR (measles, mumps, rubella).** If you need these tests, we can do them at your appointment:

- **Blood draw** → $25
- **Varicella titer** → $60
- **MMR titer** → $65
- **Hepatitis B titer** → $47

If you **refuse a vaccine for religious reasons**, we will note it on the I-693 form. You will need a **waiver from USCIS**.

After Your Appointment

- It takes **about 1 week** to complete your I-693 form.
- We will give you a **sealed envelope** for USCIS and an **extra copy for you**.
- You can **pick it up** or we can **mail it to you.**

For more information:

- I-693 Form
- USCIS Vaccine Requirements
- CDC Tuberculosis Information

Thank you for choosing Champlain Medical. We look forward to helping you!

Date: _____

I, _____ acknowledge that I have read the information in our immigration information sheet and understand that

1. The fees are **not** eligible to be covered by insurance
2. Payment is due at the **time of service**
3. If I am unable to communicate in English, I must bring to the exam an **interpreter.**
4. Failure to cancel your appointment within 48 hours of the appointment will incur a **no show $220 fee/person**
5. Champlain Medical is **not responsible** if your paperwork is denied because of missing immunizations or other testing we prescribed.
6. Any requirement to replace sealed envelopes are **subject to $110 fee** for administrative and physician review and signature.

_____

Signature of individual or guardian

Report of Immigration Medical Examination and Vaccination Record

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

USCIS
Form I-693
OMB No. 1615-0033
Expires 06/30/2025

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

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon.)

1. Your Full Legal Name (**Do not** provide a nickname)

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

2. Current Physical Address

In Care Of Name (if any)

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

City or Town | State | ZIP Code

Province | Postal Code | Country

3. Other Information

A. Sex ☐ Male ☐ Female

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

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
▶ A-

F. USCIS Online Account Number (if any)
▶

4. Immigration Medical Examination Requirement

A. ☐ I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

Applicant's Contact Information

Provide your daytime telephone number, mobile telephone number (if any), and email address (if any).

1. Applicant's Daytime Telephone Number

2. Applicant's Mobile Telephone Number (if any)

3. Applicant's Email Address (if any)

Applicant's Certification and Signature

I certify, under penalty of perjury, that I provided or authorized all of the responses and information contained in and submitted with my application, I read and understand or, if interpreted to me in a language in which I am fluent by the interpreter listed in **Part 3.**, understood, all of the responses and information contained in, and submitted with, my form, and that all of the responses and the information are complete, true, and correct. I understand the purpose of this immigration medical examination, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false or altered information or documents with regard to my immigration medical examination, I understand that any immigration benefit I derived from this immigration medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for an immigration request and to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.

4. Applicant's Signature ➡

Date of Signature (mm/dd/yyyy)

Part 3. Interpreter's Contact Information, Certification, and Signature

Interpreter's Full Name

1. Interpreter's Family Name (Last Name)

Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name

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)

Champlain Medical Urgent Care

Patient Name: _____

Yes	No	List allergies you have:
		Drug Allergies (specify):

Yes	No	List medications you take:
		Medications (specify):
1.		
2.		
3.		
4.		
5.		

Yes	No	Do you have any of the following?
		Cancer History
		Asthma
		Heart Disease
		Depression / anxiety
		Diabetes
		High Cholesterol
		High Blood Pressure
		Heartburn
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Do parents/siblings have any of the following?
		Cancer or Leukemia:
		Diabetes:
		Heart Disease:
		High Blood Pressure:
		Strokes:
		Mental Illnesses:

Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Day.
		Alcohol Use: How much ? _____ Day..

Yes	No	Are you employed?
		Employer:
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?

		Left or right handed? ☐ Left ☐ Right
		Last Tetanus shot date?

Are you experiencing any of the following conditions/symptoms TODAY?

Yes	No	CONSTITUTIONAL
		Change in appetite
		Chills
		Fatigue
		Fever
Yes	**No**	**EYES AND VISION**
		Blurred vision
		Eye pain
Yes	**No**	**EARS, NOSE , THROAT, TEETH**
		Dizziness
		Ear pain
		Nasal congestion
		Sore throat
Yes	**No**	**CARDIOVASCULAR / HEART**
		Chest pain or pressure
		Fainting
		Irregular heart beat
Yes	**No**	**RESPIRATORY / LUNGS**
		Cough
		Shortness of breath
		Wheezing
Yes	**No**	**GASTROINTESTINAL SYSTEM**
		Abdominal pain
		Diarrhea
		Nausea
		Urinary / Bowel changes
		Vomiting

Yes	No	GENITOURINARY
		Frequent urination
		Painful urination
Yes	**No**	**MUSCULOSKELETAL**
		Joint pain
		Muscle pain
Yes	**No**	**SKIN**
		Rash / Itching
		Skin sores
Yes	**No**	**NEUROLOGICAL**
		Headache
		Light headedness
		Numbness
		Poor balance
		Tingling
		Weakness
Yes	**No**	**PSYCHIATRIC**
		Anxiety/Nerves
		Depression
Yes	**No**	**ENDOCRINE SYSTEM**
		Diabetes
		Hyper or hypothyroid
Yes	**No**	**HEMATOLOGIC/BLOOD DISORDERS**
		Anema
		Swollen glands
Yes	**No**	**IMMUNE SYSTEM**
		Frequent Infections

HOW CAN WE HELP YOU TODAY?

Signature: _____ **Date:** _____

Patient Vitals: Chief Complaint ____ Height ____ Weight ____ Temp ____ BP ____ / ____ Pulse ____ O2sat % ____ Room ____