



Champlain Medical – Immigration Exam Information

Address: 150 Kennedy Drive, South Burlington VT 05403

Phone: 802-448-9370

Fax: 802-448-1414

Email: l693@champlainmedical.com

Website: www.champlainmedical.com

Hours: Monday thru Friday from 8 am to 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 and Payment

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

- Medical Exam
- Vaccination review
- Mailing of the form or in office pickup
- This does not include lab tests which are required and are at an extra cost.

We do not accept insurance for this fee. Payment is due at the visit. 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 charge **\$220**.

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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**)
 - a. Blood Test (IGRA) **\$85**
 - b. If positive, a chest X-ray will be needed (extra cost)
2. **Syphilis Test** (required for **ages 18-44**)
 - a. Blood test **\$20**
3. **Gonorrhea Test** (required for **ages 18-24**)
 - a. 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. Pages 1 & 2 of the I693 form
2. Champlain Medical's Medical Review Form
3. Patient acknowledgement form
4. Any vaccination records
5. Tuberculosis Treatment Records if 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.

Please wait 2 business days before calling us.

Important Appointment Information

- Bring a valid photo ID (passport or government issued ID)
- Bring copies of vaccines you did not already email us
- Arrive 15 minutes early

If you do not speak English, you must bring an interpreter with you. This can not be done over the phone.

Vaccine Requirements

You must be up to date with all required vaccines. For Adults that includes;

1. Polio
2. Tdap or Td
3. MMR
4. Hepatitis B
5. Varicella
6. Influenza when in season

For children, it is based on age.

We recommend getting vaccines before your appointment if you can. You can

- Get vaccines at a pharmacy
- Get vaccines at your primary care providers
- Get vaccines from us. (\$20 per vaccine, during influenza season 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 perform them at your appointment:

Varicella titer \$25

MMR titer \$65

Hepatitis B titer \$47

If you refuse a vaccine for religious reasons, we will not list it on the I-693 form. You will need a waiver from USCIS.

After your Appointment

It takes 7-10 business days 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.

Thank you for choosing Champlain Medical. We look forward to assisting you with this process.

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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 09/30/2027

▶ **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- <input type="text"/>

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):
Are you experiencing any of the following conditions/symptoms <u>TODAY</u> ?		
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	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? <input type="checkbox"/> Left <input type="checkbox"/> Right
		Last Tetanus shot date?

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
		Anemia
		Swollen glands
Yes	No	IMMUNE SYSTEM
		Frequent Infections

HOW CAN WE HELP YOU TODAY?

Signature: _____

Date: _____

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