Address: 150 Kennedy Drive, S. Burlington, VT, 05403
Phone: (802) 448-9370
Fax: (802) 448-1414
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Monday-Friday, 8AM-5PM
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Immigration Letter

This letter is provided to anyone needing to complete the I-693/Immigration physical examination, which must be done by a doctor called a Civil Surgeon. To schedule your appointment, we will need you to fill out and return the forms provided at the end of this letter, as well as provide a deposit of $220/person. This deposit can be used to cover the cost of the physical exam and will only be refunded if you cancel with at least 48 hours' notice. Anyone unable to communicate with the Civil Surgeon in English will be responsible for providing their own interpreter, who must come in person to the appointment to sign page 2 of the paperwork. We will be unable to see you or refund your deposit if you arrive without your interpreter, if you arrive more than 15 minutes late or if you miss your appointment.

Prior to calling to make your appointment, please make sure you have sent us the following.

☐**The first 2 pages of the I-693**
☐**Review of Systems (ROS)**
☐**Any vaccination records you have**

Pricing and Information

Physical Exam: $220.00 (NOT ACCEPTED BY INSURANCE)
This is the price of the physical exam only. It does not include the cost of the required laboratory testing or vaccinations, which depend on your age (more information on page 2). You can use the information for your age requirements on the following pages to check what you will need and calculate the cost. We will require payment in full before you receive your sealed envelope.

When you come in for your appointment, please make sure you bring:
☐A valid photo passport or official federal/state photo ID that is current and not expired.
☐Any physical immunizations or medical records, even if you have already sent them.

Required Laboratory Test Pricing: **Depends on your age.**

Depending on your age you will be required to have blood and/or urine testing done. According to the CDC and USCIS, these required tests can only be accepted if they are ordered by the civil surgeon on the same date as the physical exam. The lab tests must be performed by the civil surgeon's choice of laboratory so any outside test results cannot be accepted. This rule does not apply to titer results or immunization records. The pricing and age requirements for each test are listed below.

- *Tuberculosis - **$85*** – **Required for ages 2 and older**, this is a blood test called a QuantiFERON or IGRA test. Tuberculosis is commonly screened by a skin test called a PPD, which is not accepted. *You must disclose any prior history of tuberculosis you have to the civil surgeon.*
- *Gonorrhea/Chlamydia - **$20*** – **Required for ages 18-24 only**, urine test.
- *Syphilis - **$20*** – **Required for ages 18-44 only,** blood test.
- *Venipuncture - **$25*** - Charge for having your blood drawn by our staff. Only one charge per blood draw.

Required Vaccination Pricing: Depends on your age.

Just like the required laboratory testing, your age determines which vaccinations you are required to have received. For us to complete your paperwork, you will need to show that you have either received the required vaccine or that you have developed immunity to what the required vaccine is protecting against. Immunity can be shown through a blood test called a titer for certain viruses: Hepatitis A & B, MMR (Measles, Mumps, Rubella), Polio, and Varicella (chicken pox). More information about titers and their pricing can be found on page 4 of this letter under 'optional laboratory testing'.

Table 1: Vaccine Requirements According to Applicant Age for Civil Surgeons

Vaccines by applicant age	Birth– 1 month	2–11 months	12 months–6 years	7–10 years	11–17 years	18–64 years	≥ 65 years
DTP/DTaP/DT	NO	YES		NO			
Tdap/Td	NO			Sometimes*	YES Refer to ACIP Tdap/Td notes for adults without history of primary vaccination series		
Polio	NO	YES Refer to ACIP Poliovirus notes for adults without history of primary vaccination series					
Measles, Mumps, and Rubella	NO		YES, if born in 1957 or later				NO
Rotavirus***	NO	YES Six weeks to eight months	NO				
Hib	NO	YES 2 through 59 months old		NO			
Hepatitis A	NO		YES 12 months through 18 years old			NO	
Hepatitis B	YES, through 59 years old						NO
Meningococcal (MenACWY)	NO				YES 11 through 18 years old	NO	
Varicella	NO		YES				
Pneumococcal	NO	YES, 2 through 59 months old (Administer PCV)		NO			YES
Influenza	NO, if less than six months old	YES, ≥6 months (Annually. See ACIP notes for more information)					
COVID-19	NO, if less than six months old	YES, ≥6 months See COVID-19 section for additional information					

On the chart above, start in the top row at your age and move down the column to see which vaccinations you need. For example, if you are between the ages of 19-64, you will need Tdap, Polio, MMR, Hepatitis B, Varicella, Flu, and Covid-19. Anyone 65 and older will need Tdap, Polio, Varicella, Pneumococcal, Flu, and Covid-19. This chart is provided by the CDC. A more detailed chart can be reviewed on their website linked at the end of this letter.

Our Vaccination Pricing:

- *Tdap (Tetanus, Diphtheria, Pertussis) -* ***$20*** **–** Booster shot is required within the last 10 years.
- *Polio -* **$20** – Series of 3 shots, given at: 0, 1-2 months after first, 6-12 months after second.
- *Hepatitis B -* ***$20*** – Series of 3 shots, given at: 0, 1-2 months after first, 4-6 months after the first shot.
- *MMR* (*Measles, Mumps and Rubella) -* ***$20*** – Typically 1 shot, high risk patients may require a series of 2 given at: 0, 4 weeks after the first shot.
- *Varicella (also known as Chicken Pox) -* ***$20*** – Series of 2 shots given at: 0, 4-8 week later.

- *Influenza* (Flu) - ***$34*** – Required whenever it is routinely available in the area.
- *Covid-19* ***-$20*** - Required for patients 6 months and older. As of 11/03/2023, you must receive at least 1 dose of an updated (2023-2024) Covid-19 immunization. In other words, if your last Covid-19 shot is not the most recent formula, you will need a booster.

Other Vaccination Notes:
Series - Some vaccinations are given in a series, meaning you must receive at least one booster shot after the first shot. You are only required to have the first shot of the series to complete the paperwork; with the understanding and assumption that you will receive the rest of the series on your own. You are welcome to return to our clinic to do this, each shot of the series is administered for the price given above. The series spacing times are listed next to each immunization.

Declining Vaccinations: You may decline a required vaccination if you have a documented contraindication to it, meaning it would cause you to have a life-threatening reaction. You may also decline an immunization without having a contraindication and submit your paperwork, however it is very likely it will be rejected by USCIS. If this happens you may need to get the vaccination and/or restart the entire process and submit it again. If you wish to decline a vaccination for religious reasons, you will need a waiver provided by an officer from the USCIS office. In this event we would simply mention that you are using an exemption waiver on page 13 of the paperwork. Please see the links on the last page for further immunization information and related questions/answers about vaccinations.

Optional Laboratory Test Pricing:
Titers: As mentioned above, a titer is a blood test used to check for certain antibodies and is a useful tool if you have immunity but cannot provide any record of it. If, for instance, you had Chicken Pox/Varicella in the past or if you were previously immunized but cannot prove it, a titer can be done instead of receiving the Varicella shot. You should not get a titer if you believe you don't have immunity, as a negative titer result would indicate that you still need to receive the vaccine(s).
MMR Titer - $65.00 – Please note that a negative titer result for either Measles, Mumps or Rubella will require the vaccination of all 3, since they are given simultaneously in a single shot.
Varicella Titer -$60.00 - Recommended if you have been previously immunized or have a history of chicken pox.
Hepatitis B Titer - $47.00 – *Recommended if you have previously been immunized for Hepatitis B.*

Polio Titer*: *$75.00 – Most countries give the Polio vaccine during childhood in a series of 4 shots. This test can take several weeks for the results to come back so it is not recommended if you are in a hurry.

More Information and Resources:

Abnormal Lab Results:

STI: If any of the test results for sexually transmitted diseases come back positive, you will be required to receive treatment and provide documentation of your treatment before your paperwork can be completed.

Tuberculosis: If your tuberculosis test result is positive, you will be required to get a chest x-ray to determine if you have active or latent tuberculosis. Those with an abnormal chest x-ray may be diagnosed with active tuberculosis, which requires further treatment before the paperwork can be completed.

Those with a positive tuberculosis test result and a normal chest x-ray may be diagnosed with latent tuberculosis. Patients with latent tuberculosis will still receive their completed paperwork but they must follow up with their doctor to receive treatment. If you do not have a primary care provider, the civil surgeon can assist with a treatment plan. This would be a separate visit from the immigration physical and would have no impact on the immigration paperwork. All patients with a positive tuberculosis blood test will be reported to the VT Department of Health and USCIS as it is mandated.

More information about tuberculosis is beyond the scope of this letter and should be discussed with the civil surgeon, there is also more information on the link on the last page of this letter.

Turnaround Time: You should allot about an hour to get your physical exam and lab work done; more time will be required if you need numerous immunizations. You can reduce your office visit time by getting your immunizations and/or titers done prior to your appointment and sending the records to us. After getting your blood drawn on Wednesday, the results typically return 5 days later, on Monday. If your test results are normal and you have all the required vaccinations, we will pack your paperwork into a sealed envelope and call you to either pick it up at our office or we will verify the address you would like it mailed to using 2-day USPS priority shipping. We will provide you with a copy of the contents of the sealed envelope (which is just the 14 page, I-693 document) as well as copies of your immunization records and lab results.

Insurance: Unfortunately, insurance will not cover the immigration physical exam or required components. We can only run the Hepatitis B and Tdap vaccinations through your insurance if you tell us beforehand and provide us with your insurance information. This is because our immunizations are provided by the state of VT, although we also stock a non-state-provided supply of these two only. The state-provided vaccines allow us to offer them at the given prices but prevent us from being able to run them through insurance. Insurance will not cover the required testing, so all samples are sent to a lab out of state to offer you the lowest rates possible. You may use your insurance to get the required vaccines through your own doctor or outside clinic and provide us with the records. You may also use your insurance to get titers, we can write the lab orders for you, or you may go through your own doctor or outside clinic. Even if we provide the lab order, you will be responsible for any remaining balance to the lab after it has been run through your insurance. As a reminder, the required STI and tuberculosis testing must be done through our clinic/lab on the day of your physical.

The links below are referenced in this letter and provide a more useful information, including frequently asked questions and detailed overviews of the requirements.

- https://www.uscis.gov/i-693
- https://www.uscis.gov/tools/designated-civil-surgeons/vaccination-requirements
- https://www.cdc.gov/tb/about/index.html
- https://www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/index.html
- https://www.cdc.gov/pinkbook/hcp/table-of-contents/index.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/index/html

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 03/31/2025

► **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. Gender ☐ 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 ____