# *VISA INFORMATION*

*Please, read CAREFULLY all the information on this document. Complete the form at the end of the Instructions and read the Important Information from the US Embassy regarding your Consent at the final page of this Document.*

## *GENERAL CONSIDERATIONS*

*Medical examinations for visa are carried out from Monday to Friday in the mornings.*
*It will be necessary to make an appointment by calling us on 914351823, from Monday to Friday, 9 a.m. to 3 p.m.*

### *ON THE DAY OF YOUR MEDICAL EXAMINATION YOU WILL NEED:*

- *Appointment confirmation page (with the appointment date with the Embassy).*
- *6 passport size photographs (Spanish or American passport size).*
- *Your original passport.*
- *CEAC confirmation page (DS-260 or DS-160).*
- *Visas form and the end of this document.* ***Please, print & fullfil. Then, bring it with you to the Clinic.***
- *Know the Visa Category you are applying for (Immigrant Visa, Refugee, Asylee, Non-Immigrant Visa or Parolee).*
- *Vaccination record. (see page 4, Vaccinations).*
- *Your* ***full*** *address in United States.(Address, Postal Code, City and State).*
- *Children and candidates under the age of 18, must come to the appointment with their parents or legal representatives, and with their respective passports.*

## *TYPES OF VISA.*

A. *Immigration visa for children under the age of 2.*
B. *Immigration visa for children between the ages of 2 & 14.*
C. *Immigration visa for candidates over the age of 15.*
D. *Fiancée Immigration visa (K-1).*
E. *Immigration / Non-immigration visa (alcohol, drugs, psychiatric disease.)*

## A. *IMMIGRATION VISA FOR CHILDREN UNDER THE AGE OF 2.*

- *A Medical check-up will be performed.*
- *Review of the Vaccination Calendar. (See page 4, Vaccinations.)*
- *It costs 155 Euro.*

## B. *IMMIGRATION VISA FOR CHILDREN BETWEEN THE AGES OF 2 & 14.*

- *A Medical check-up will be performed.*
- *Review of the Vaccination Calendar. (See page 4, Vaccinations.)*
- *IGRA Quantiferon G. (blood screening)*
- *It costs 330 Euro.*

## C. *IMMIGRATION VISA FOR CANDIDATES OVER THE AGE OF 15.*

- *A Medical check-up will be performed.*
- *Review of the Vaccination Calendar. (See page 4, Vaccinations.)*
- *Blood test to detect syphilis (VDRL). It will not be necessary to fast beforehand.*
- *Urine test to detect Gonorrhea by **NAAT** (nucleic acid amplification test). Sample is taken at the Clinic ONLY.*
- *Chest x-ray. It will be performed on the same day of the examination, at the Doctores Sales clinic, after the medical examination and without prior appointment.*
- *It costs 393 Euro.*
- *Though pregnant, chest x-ray is expected to be performed. It is important that you tell the Doctor at the Medical Check Up if you are pregnant, or if you think that you could be.*

## *D. FIANCÉE IMMIGRATION VISA (K-1).*

- *A Medical check-up will be performed.*
- *Blood test to detect syphilis (VDRL). It will not be necessary to fast beforehand.*
- *Urine test to detect Gonorrhea by **NAAT** (nucleic acid amplification test). Sample is taken at the Clinic ONLY.*
- *Chest x-ray. It will be performed on the same day of the examination, at the Doctores Sales clinic, after the medical examination and without prior appointment.*
- *It costs 393 Euro.*
- *Though pregnant, chest x-ray is expected to be performed. It is important that you tell the Doctor at the Medical Check Up if you are pregnant, or if you think that you could be.*

- *Although NO Vaccinations ARE requested by Local US Consulate, they will do become compulsory once entered in the US. A Review of the Vaccination Calendar can be performed. (See page 4, Vaccinations).*

## *E. IMMIGRATION / NON-IMMIGRATION VISA (HISTORY OF ALCOHOL, DRUGS, PSYCHIATRIC DISEASE).*

- *A full Medical check-up will be performed.*
- *Costs with history of alcohol 393€. If history of alcohol and drugs 478€.*
- *No Vaccinations needed*

## *Vaccinations:*

*In the following page you will find a chart with the vaccines demanded by the US Embassy.*
*Check the chart according to YOUR age today and see that they appear in your vaccination records.*
*If the vaccines you need are not registered on your records or if you don't have any vaccination document,, here are your alternatives:*

- *You can get those records from your family Doctor.*
- *You can get a blood screening for the MMR & Chickenpox to check for IgGs. You can do this with us, or with your family Doctor. If you choose the latter, you should bring the results to the appointment at your medical check up with us (consider the time you will need to get these results from your family Doctor).*
- *We can provide for the vaccines you need. Prices on chart.*

## *VACCINATION CHART. (Applicable to patient´s age. See Specifications 2nd column)*

| VACCINE | SPECIFICATIONS | PRICES |
|---|---|---|
| DTP/DTaP/DT | From 2 months to 6 years old | 15 Euro |
| Td/Tdap * | From the age of 7 | 30 Euro |
| Polio (IPV/OPV) | From 2 months to 17 years old | 15 Euro |
| MMR ** | Between the ages of 1 and 47. | 30 Euro |
| Rotavirus | From 6 weeks to 8 months | Available upon request |
| Hib (Haemophilus influenzae Type B) | From 2 months to 5 years old | 15 Euro |
| Hepatitis A | From 12 to 23 months old | Available upon request |
| Hepatitis B | Children under the age of 18 | Available upon request |
| Meningococcus | From 11 to 18 years old | 15 Euro |
| Chickenpox *** | From the age of 15 months | 70 Euro |
| Pneumococcus | From 2 months to 5 years old and older than 65 | 15 Euro |
| Influenza (flu) | 6 months and older (Only in Autumn-Winter). | 25 Euro |

** Tetanus-diphtheria vaccine lasts for ten years, followed up by booster doses.*
*** A blood test that indicates positive antibodies can be used as proof of the MMR, (Measles IgG, rubella and mumps).*
**** A blood test that indicates positive antibodies can be used as proof of the Chickenpox, (Chickenpox IgG).*

## *WHEELCHAIR:*

*Please let us know on your call for the appointment, that you use a wheelchair so as to coordinate all the process on only one site (Radiology Clinic).*

## *COLLECTION OF RESULTS.*

*Results must be collected **in 5 business days** from the date of your appointment from Monday to Friday. If your exam was on Monday, you can collect it the following Monday.*

*Results should be collected in person or by someone previously authorized to do so in writing. Immigration visa for children that include the Mantoux test can be collected after 48 hours.*

*THE MEDICAL EXAMINATION IS VALID FOR A PERIOD OF 6 MONTHS.*

Unidad Médica ANGLOAMERICANA

E: ☐ M:☐

**FECHA DE EXAMEN: ……..……..**

**Nª DE HISTORIA: ……**

**NOMBRE (Name): ……. APELLIDOS (Last Name):…….…….**

**LUGAR DE NACIMIENTO (CIUDAD Y PAIS) (Place of Birth, City and Coutry):……..……..……..**

**EDAD (Age) /FECHA DE NACIMIENTO (Date of Birth): ..…….**

**RESIDENCIA ACTUAL COMPLETA (Present Full Address): ……..**

**..……..……..**

**TELÉFONO (Phone):……**

**RESIDENCIA EN USA COMPLETA:…….…….…….....**
**(FULL ADDRESS IN USA)**

**SEXO (Sex): ☐ MUJER (Female) ☐ ☐ VARON (Male) ☐**

**NUMERO DE PASAPORTE (Passport Number): ……..…**

**MEDICO EN UNIDAD MEDICA : ☐DR. GONZALEZ ☐DR. REVERTE ☐DR. SOLIS**

**PENDIENTE: ☐PASAPORTE . ☐FOTOS. ☐ VACUNAS. ☐MANTOUX.**

**Email:…….**

**TIPO DE VISADO (Type of Visa):**

**Immigrant Visa…….☐ Immigrant ☐Special Immigrant ☐Diversity ☐Adoptee**

**Refugee…….. ☐ Refugee ☐Visa 92**

**Asylee……. ☐ Asylee ☐ Visa 93**

**Non Immigrant Visa. ☐ K-Visa ☐ Other Non Immigrant Visa**

**Parole …… ☐ Parolee**

**FECHA ENTREVISTA EN LA EMBAJADA:……...**
**(Appointment date at the Embassy)**

**FIRMA DEL INTERESADO: ……..**

**PLEASE TURN OVER / DE VUELTA LA HOJA POR FAVOR**

## CONSENTIMIENTO PACIENTES

Madrid, en fecha .....

Unidad Médica, s.l. es el **Responsable del tratamiento** de los datos personales del **Interesado** y le informa de que estos datos se tratarán de conformidad con lo dispuesto en el Reglamento (UE) 2016/679, de 27 de abril (GDPR), y la Ley Orgánica 3/2018, de 5 de diciembre (LOPDGDD), por lo que se le facilita la siguiente información del tratamiento:

**Fines y legitimación del tratamiento**: prestación de servicios profesionales de salud y mantenimiento del historial clínico (por consentimiento del interesado, art. 6.1.a GDPR).

**Criterios de conservación de los datos**: se conservarán durante no más tiempo del necesario para mantener el fin del tratamiento o mientras existan prescripciones legales que dictaminen su custodia y cuando ya no sea necesario para ello, se suprimirán con medidas de seguridad adecuadas para garantizar la anonimización de los datos o la destrucción total de los mismos.

**Comunicación de los datos**: no se comunicarán los datos a terceros, salvo obligación legal. En caso que mi prestación médica sea abonada por un tercero autorizo a Unidad Medica SL a compartir la información médica o general que sobre mi persona deba transmitir a estos terceros para reclamar los pagos debidos.

**Derechos que asisten al Interesado**: - Derecho a retirar el consentimiento en cualquier momento. - Derecho de acceso, rectificación, portabilidad y supresión de sus datos y de limitación u oposición a su tratamiento. - Derecho a presentar una reclamación ante la Autoridad de control (www.aepd.es) si considera que el tratamiento no se ajusta a la normativa vigente.

**Datos de contacto para ejercer sus derechos:**

Unidad Médica, s.l.. C/ Conde de Aranda, nº 1, 1º-Izq. - 28001 Madrid (Madrid). Email: crey@unidadmedica.com

Datos de contacto del delegado de protección de datos: PLAZA PADRE JUAN DE MARIANA, 10, 1ª PL, 45600 TALAVERA DE LA REINA - dpd@ciberbot.com

El **Interesado** o su representante legal consiente el tratamiento de sus datos en los términos expuestos:

Nombre ....., con NIF .....

Representante legal de ....., con NIF .....

Firma:

## PATIENT CONSENT

Mr/Mrs/Ms……. Pass/DNI/NIE……

According to the **Reglamento (UE) 2016/679, and Ley Orgánica 3/2018, (LOPDGDD)**, we inform you that your data will be recorded on a file under Unidad Medica SL responsibility with the only purpose of dealing with the “doctor-patient” relationship. I authorize Unidad Medica SL to release any medical or general information about me to my Insurance Carrier or any third party responsible for my bills in order to make any relevant claims.

You are fully entitled to access, modify or cancel these records by writing a letter to “Unidad Medica SL” Calle del Conde de Aranda Nº1, 1º Izquierda 28001 – Madrid.

We will consider and keep your records as accurate until we know from you otherwise. You will contact us to inform of any modification and we have your consent to use your records so as to assist you with medical attention and to manage your medical records.

Madrid, 201

Signature

**Consent Related to Medical Examination for Applicant Using the DS-2054**

I understand that I am required to undergo a complete medical examination with an authorized physician in order to assess my eligibility consistent with Immigration and Nationality Act (INA) Sections 212(a) and 221(d). I understand that failure to provide required information may cause delay or denial of visa.

I understand that all applicants 15 years of age and older are required to undergo a chest radiograph (x-ray) to test for tuberculosis. I understand that if I am pregnant at the time of my initial medical exam I must consent and will be provided with abdominal and pelvic protection with double-layer, wrap-around lead shields. I understand that if I am pregnant I may refuse the chest radiograph. If I refuse the chest radiograph I understand that my visa application will not be processed until I have completed the requirement.

I understand that any willfully false or misleading statement or willful concealment of material fact made by me herein may subject me to permanent exclusion from the United States or may subject me to criminal prosecution and/or deportation.

The information provided on your medical examination report may be accessible to other government agencies having statutory or other lawful authority to use such information, including for the administration or enforcement of the immigration, nationality, and other laws of the United States.