COVID-19 Self-Declaration Form

First name | **Last name** | **Sex**

Have you travelled abroad during 2020?

Yes ☐ No ☐

ID number

Countries Visited	Dates of Travel

Have you been in contact with people infected, suspected or diagnosed with COVID-19?

Yes ☐ No ☐

Relationship with infected person	Last contact date with person

Please state whether you are experiencing the any of following (tick appropriate box)

Symptoms	Yes	No
Fever		
Cough		
Shortness of breadth		
Persistent Pain In the Chest		
Sore Throat		

I acknowledge that the information I've given is accurate and complete.

Signature

Date