Health Certificate for COVID-19

Name (First, Last)	
Gender	☐ Male ☐ Female
Age	y/o
Date of Birth (dd/mm/yyyy)	/ /
Nationality	
Passport No.	

1) Date of Examination (dd/mm/yyyy)	/ /
2) Close contact with a person with COVID-19 (probable or confirmed) while they were ill without taking appropriate precautionary measures within the last two weeks.	YES / NO
3) Clinical symptoms such as cough, shortness of breath, chills, fatigue, muscle pain, headache, sore throat, vomiting, diarrhea, or new loss of taste or smell.	YES / NO
4) Clinical Manifestation	BT:_____℃ Others:

5) Testing for COVID-19 (examined on the same day as the examination)

Sample	Testing for COVID-19	Laboratory result
■Nasopharyngeal swab ☐ Saliva	■ Nucleic acid amplification test (Real Time RT-PCR) ☐ Nucleic acid amplification test (LAMP) ☐ Antigen test (CLEIA)	Negative (Not detected) *Sample Date (dd/mm/yyyy); / /

Based on the above information, the person named above is currently healthy and unlikely infected with SARS-CoV-2. Therefore, he or she is fit for flight/work at the current health condition.

Date of Issue (dd/mm/yyyy)： ____/____/____

Signature of Physician： _____

Name of Physician(Printed)：