|  |  |  |  |
| --- | --- | --- | --- |
|  | Nationality |  | Full Name |
|  | Flight number |  | Country of Departure |
|  | | | Address at the country of arrival |
|  | Date of birth |  | National Number |
|  | Date |  | Gender |
|  | Mobile # and email |  | Address |

Please answer the following questions by (YES or NO) by putting the mark √ in the right place. If the answer is yes, clarify under remarks.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Remarks | No | Yes | Question | # |
|  |  |  | Are you suffering from any of the following symptoms?  Body temperature over 38 Degrees, Dry cough, Constant sneezing, Shallow breathing, losing the sense of smell and taste, Nausea or Diarrhea | 1 |
|  |  |  | Have you had any contact with someone infected with COVID19 | 2 |
|  |  |  | Have you had any contact with someone with any of COVID19 Symptoms | 3 |
|  |  |  | Did you travel during the past 28 days? If yes, indicate name of countries | 4 |

I the undersigned; acknowledge and declare that all above information are correct and otherwise I bear full responsibility, and I commit myself to follow all health precautionary measure of the ministry of health.

Signature:

GO/44/20