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| **Health Questionnaire /Medical Report 3 (Completed by Authorized Physician)** |
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| Basic Information of Applicant | Name  |  |
| Nationality  |  |
| Birth Date(YY/MM/DD) |  |
| Please list the countries where this person has stayed during the past 10 days. |
| 1)  | 2)  | 3) |
|  |
| Please check a mark "∨", if the person has or has had any of the following symptoms during the past 10 days. |
| [ ] Runny or stuffy nose | [ ] Sore throat | [ ] Cough | [ ] Fever  |
| [ ] Diarrhea | [ ] Vomiting | [ ]Abdominal pain  | [ ]Difficulty breathing | [ ]Shortness of breath |
| I certify that I have answered all questions truthfully and completely to the best of my knowledge.Name of Clinic : Address of Clinic : Name of Physician : Date : Signature :  |