|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Questionnaire /Medical Report 3 (Completed by Authorized Physician)** | | | | | | | | | | | |
|  | | | | | | | | | |  | |
| 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 : | | | | | | | | | | | |