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 "V", if the person has or has had any of the following symptoms during the past 10 days.

[ ] Fever	[ ] Maculopapular rash	[ ] Joint pain
[ ] muscle pain	[ ] conjunctivitis (red eyes)	[ ] headache

I certify that I have answered all questions truthfully and completely to the best ofmy knowledge.

Name of Clinic :

Address of Clinic :

Name of Physician :

Date :

Signature :