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| **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. | | | | | |
| [ ] 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 of my knowledge.  Name of Clinic :  Address of Clinic :  Name of Physician :  Date :  Signature : | | | | | |