

## Travel Self-Declaration Form

To protect your health and the community's health, **Abu Dhabi Public Health Center and the Department of Health Abu Dhabi** require you to complete this form. Your information will assist health authorities in contacting you if you were exposed to COVID-19. It is important to fill out this form completely and accurately. Your information will be held in accordance with applicable laws and used for public health purposes only.

Self-Declaration Form	Flight details	
<p>1) <b>Have you been admitted to a healthcare facility during the last 14 days?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, what was the date of admission?</p> <p>What was the date of discharge?</p>	Airline:	Flight Number:
<p>2) <b>Have you come into contact with anyone with a respiratory illness during the last 14 days?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, what was the date of contact?</p>	Seat Number:	Coming from:
<p>3) <b>Have you been in transit?</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, please state the country and duration.</p>	Transit through (country):	Duration of stay in transit (days):
<p>4) <b>Are you currently having any of the symptoms listed below?</b></p> <p><input type="checkbox"/>Fever</p> <p><input type="checkbox"/>Cough</p> <p><input type="checkbox"/>Shortness of breath</p> <p><input type="checkbox"/>Sore throat</p> <p><input type="checkbox"/>Muscle pain</p> <p><input type="checkbox"/>Headache</p> <p><input type="checkbox"/>Loss of sense of taste or smell</p> <p><input type="checkbox"/>Other, specify:</p>	Date of arrival:	
	<b>Traveler's details</b>	
	First name:	Nationality:
	Family name:	Gender:
	Passport Number:	Age:
	<b>Address in the UAE</b>	

If yes, when did you start having symptoms?	Place of work: Employer's name:	Residence address: Emirate: Building name: Flat/villa number:
	Mobile number: Home number: Email address:	

Q1: Do you have any other family members traveling with you? (If yes, please specify the number of family members, their relationship to you, their gender and age)

Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Q2: Do you have any medical conditions? (If yes, please specify)

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Q3: Are you currently taking any medication? (If yes, please specify)

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Q4: Do you have any allergies? (If yes, please specify)

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Q5: Do you have any people of determination traveling with you? (If yes, please specify their type of disability)

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Q6: How long did you stay at your previous destination?

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Q7: Did you take a COVID-19 PCR test during your stay at your previous destination? (If yes, please mention the test date and result)

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Q8: Do you have any other concerns? (If yes, please specify)

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Thank you for collaborating with us to protect your health and the health of others.