

**Public Health Passenger Locator Form:** To protect your health, public health officers need you to complete this form whenever they suspect a communicable disease onboard flight. Your information will help public health officers to contact you if you were exposed to a communicable disease. It is important to fill out this form completely and accurately. Your information is intended to be held in accordance with applicable laws and used only for public health purposes. ~Thank you for helping us to protect your health.

**One form should be completed by an adult member of each family. Print in capital (UPPERCASE) letters. Leave blank boxes for spaces.**

**FLIGHT INFORMATION:** 1. Airline name  2. Flight number  3. Seat number  4. Date of arrival (yyyy/mm/dd) 2020 /  /

**COUNTRIES VISITED IN WITHIN THE PAST 14 DAYS:**

CHINA: NO ☐ YES ☐

OTHER ASIAN COUNTRIES: NO ☐ YES ☐ SPECIFY:

**PERSONAL INFORMATION:** 5. Last (Family) Name  6. First (Given) Name  7. Middle Initial  8. Your sex Male ☐ Female ☐

**PHONE NUMBER(S) where you can be reached if needed. Include country code and city code.**

9. Mobile  10. Business   
11. Home  12. Other

13. Email address

**PERMANENT ADDRESS:** 14. Number and street (Separate number and street with blank box)  15. Apartment number

16. City  17. State/Province

18. Country  19. ZIP/Postal code

**TEMPORARY ADDRESS:** If you are a visitor, write only the first place where you will be staying.

20. Hotel name (if any)  21. Number and street (Separate number and street with blank box)  22. Apartment number

23. City  24. State/Province

25. Country  26. ZIP/Postal code

**EMERGENCY CONTACT INFORMATION of someone who can reach you during the next 30 days**

27. Last (Family) Name  28. First (Given) Name  29. City

30. Country  31. Email

32. Mobile phone  33. Other phone

**34. TRAVEL COMPANIONS – FAMILY:** Only include age if younger than 18 years

	Last (Family) Name	First (Given) Name	Seat number	Age <18
(1)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**35. TRAVEL COMPANIONS – NON-FAMILY:** Also include name of group (if any)

	Last (Family) Name	First (Given) Name	Group (tour, team, business, other)
(1)	<input type="text"/>	<input type="text"/>	<input type="text"/>
(2)	<input type="text"/>	<input type="text"/>	<input type="text"/>

## ATTACHMENT to State letter EC 6/3 - 20/90

# **PUBLIC HEALTH COVID-19 PASSENGER SELF DECLARATION FORM**

*Proposal – a health declaration to include on the reverse of the existing PLF.*

<b>PUBLIC HEALTH COVID-19 PASSENGER SELF DECLARATION FORM</b>			
<b>Purpose of this form:</b> This form is intended to support public health authorities by allowing arriving passengers to easily provide relevant information pertaining to their health status, particularly with regard to COVID-19. Information needs to be recorded by an adult member of the group or travel group. Notwithstanding completion of this form, a passenger might still be subjected to additional health screening by the Public Health Authority as part of a multi-layer prevention approach. Your information is intended to be held in accordance with applicable national laws and used only for public health purposes.			
<b>1) Traveller Information:</b>  <div> <b>First Name(s):</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <b>Last Name(s):</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <b>Date of Birth (dd/mm/yyyy):</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <b>Travel document No. &amp; issuing country:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <b>Country of residence:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <b>Port of Origin:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>			
<b>2) During the past 14 days, have you, or a member of your group travelling with you, had close contact (face-to-face contact for more than 15 minutes or direct physical contact) with someone who had symptoms suggestive of COVID-19?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3) Have you, or any member of your group travelling with you, had any of the following symptoms during the past 14 days:</b>  <div> Fever      Yes <input type="checkbox"/> No <input type="checkbox"/>      Shortness of breath      Yes <input type="checkbox"/> No <input type="checkbox"/>  Coughing      Yes <input type="checkbox"/> No <input type="checkbox"/>      Sudden loss of sense of taste or smell      Yes <input type="checkbox"/> No <input type="checkbox"/> </div>			
<b>4) Have you, or any member of your group travelling with you, had a positive COVID-19 test in the last 3 days?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Please attach report if available			
<b>5) Please indicate all countries and cities that you and the group travelling with you have visited or transited through in the last 14 days (including airports and ports), providing the dates of the visit. List the most recent country first.</b>  <div> <input type="text"/> </div> <div> <input type="text"/> </div>			
<i>For more information on penalties related to the provision of false information on this form, please refer to the applicable national legislation and/or local health authorities.</i>			
<b>Signature:</b> <b>Date:</b>			