The Republic of Namibia

MINISTRY OF HEALTH AND SOCIAL SERVICES

COVID-19 SURVEILLANCE FORM

(Must be completed by all incoming travelers)

Date of arrival: _____ *Flight/vessel/name and Reg No:* _____ *Seat No:* ___

Name & Surname: _____ *Nationality:*_____

Passport Number: _____ *Arriving from:* _____*Contact No:* _____

*Emergency Contact No.*_____ ___

Intended length of stay in Namibia: ***From*** *(Date:* _____/____/_____*)* ***To*** *(Date* ___/ ____/_____*)*

Name & Physical address of intended place of stay in Namibia: _____

Contact Number of intended place(s) of stay in Namibia:

COVID-19 Negative Test Results: Yes ☐ No ☐ Date of the results: ___/____/_____

Laboratory Name:_____

Do you have any of the following signs or symptoms?
(Tick as appropriate):

Signs and symptoms	Yes	No
Fever		
Running nose		
Shortness of breath		
Headache		
Cough		
Sore throat		
Other, specify		

Should you experience of the above-mentioned signs or symptoms call the toll-free number **0800100100** or go to the nearest health facility.

Travelers' Signature: _____ **Date: ___/___/____**

Thank you