



**FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA MINISTRY OF HEALTH
ETHIOPIAN PUBLIC HEALTH INSTITUTE (EPHI)
TRAVELER'S HEALTH DECLARATION AND LABORATORY REQUEST FORM
FOR CORONAVIRUS DISEASE (COVID-19)**



Version-2.00

I. To be Filled by Arriving Passengers in the Aircraft or at Health Desk

TO PROTECT YOUR HEALTH, YOUR FAMILY, AND OTHERS, FDRE MINISTRY OF HEALTH OF ETHIOPIA/ETHIOPIAN PUBLIC HEALTH INSTITUTE (EPHI) REQUIRES YOU TO COMPLETE THIS FORM BEFORE ARRIVAL TO ETHIOPIA AND SUBMIT TO THE HEALTH DESK. YOUR INFORMATION IS HELD CONFIDENTIAL AND USED ONLY FOR PUBLIC HEALTH PURPOSES.

Have you visited any country where COVID-19 has been reported in the last 14 days? Yes No

If YES, Country/ies Province/s

Have you had contact with the COVID-19 confirmed case in the country visited Yes No

Passenger Identification Last Name First Name

Middle Name Age Sex Male Female

Occupation Government employee Self-employee No occupation Others

Nationality Country of Residence Passport No.

Date arrived in Ethiopia (DD /MM /YY) Flight Number Seat Number

Address in Ethiopia Region Zone/sub city Woreda

City Kebele House No. Local Phone No.[self/family's]

Email address:

International phone number [Country code, number]

If not resident Purpose of Travel Duration of stay

Hotel/Org Name Phone No. Local Phone No.[self/family's]

International phone number [Country code, number] Contact's local Phone No.

Email address:

Clinical Information Have you had any of the following symptoms? Yes No

Fever Cough Difficulty in breathing Sore throat Headache Easy fatigability Other

If YES, Date of onset of the symptoms

Do you have chronic illness/condition? Yes No

If yes, DM Hypertension HIV Chronic respiratory diseases Chronic cardiac diseases Cancer Pregnancy
other _____

I hereby declare that the information given above is true and correct Signature Date:

While in Ethiopia, should you need any support? Please call 24/7 toll free line (8335/952) OR email at ephieoc@gmail.com

II. To be Completed by Point of Entry Health Desk Officer

Measured Temperature(°c): Screening outcome Released Referred for further assessment

Availability of recent (within 72 hours) and valid RT-PCR test result Yes No

Completed by(Name) Date (DD/MM/YY): Signature:

III. Laboratory Information to be completed by assigned personnel

Client classification: New Repeat

Reason for testing: Passenger Other _____

Location of collection PoE-BIA Other _____

Sample information Sample type NP Swab OP swab Others

Sample collection date & Time Date: _____ Time: _____ Date & time received at testing lab Date: _____ Time: _____

Sample collected by: Phone number: Signature: