MINISTERIO DE SALUD PÚBLICA

**Dominican Republic**
**Ministry of Public Health**
Traveler´s Health Affidavit
(MSP-DJSV-01)

**1. Traveler or crew member identification**

Name(s): _____ Last name(s): _____

Sex: □ Female □ Male Date of birth: ____/____/_____
DD MM YY

Nationality _____ Passport No. _____

Permanent Residence Address

Street name and №. _____

City/Sector/Neighborhood _____

Province/State/Department_____ Country_____

Telephone number _____

**2. Trip information:**

Means of transportation: □ By air □ By sea □ By ground

Port of Entry: _____

Date of arrival: _____/_____/_____ Date of departure _____/_____/_____
DD MM YY DD MM YY

Transportation Company_____

Travel № (Flight/Ship/Car) _____

Country where your trip initiated _____

Transit countries where you have been prior to your arrival to Dominican Republic

Visited countries in the last 30 days

**3. Declaration of Symptoms:**

In the last 72 hours, have you presented one or more of the following symptoms?

□ Fever □ Respiratory distress □ Cough □ Headache □ Sore throat
□ Fatigue □ Shivers □ Ronny nose □ Muscle pain □ None

Other symptoms (Specify): _____

Date when the symptoms started: _____/_____/_____
DD MM YY

**4. Traveler´s Contact Information:**

Address of where you will be staying in Dominican Republic in the next 30 days:

**Important Note**

**I declare that the information declared in this form is true and accurate, and I accept that my false declaration is considered a violation of the national health regulations.**

_____ Date: _____/_____/_____
Traveler´s signature DD MM YY