The Republic of Namibia
MINISTRY OF HEALTH AND SOCIAL SERVICES

HEALTH QUESTIONNAIRE FOR TOURISM REVIVAL INITIATIVE TRAVELERS

(This questionnaire must be completed by all incoming travellers prior to departure)

Expected date of Arrival: _____

Flight No: _____ Seat No: _____

First Name: _____

Surname: _____

Phone Number: _____

Email Address: _____

Passport No: _____

Nationality: _____

Gender: _____ Age _____

Country of Departure, including connection stops before this trip: _____

_____

_____

Envisaged Destination in Namibia (Please list all destinations, with name of town and hotel): _____

_____

_____

_____

Intended length of stay in Namibia: _____ (Days)

Within the past 14 days have you ever been to any of the COVID-19 affected country/area?

Yes _____ No _____

If yes, which country/area? Please specify

Within the past 14 days have you had close contact with or cared for someone who has been diagnosed with COVID-19?

_____

Yes _____ No _____

Do you have any of the following signs or symptoms?

(Tick as appropriate)

Symptoms	Yes	No	Unknown
Fever			
Cough			
Chills or rigors			
Sore throat			
Shortness of breath			
Runny nose			
Headache			
Fatigue/feeling tired			
Loss of taste/smell			
Muscle pain			
Joint Pain			
Nausea			
Chest pain			
Other symptoms			

I _____ Pledge to obey all the COVID-19 Health Regulations of the Republic of Namibia.

Date: _____

Signature _____

Please go to the nearest Health facility or call the toll-free number 0800100100, should you experience any of the above-mentioned symptoms.

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