Maritime Passenger Health Screening Form

Personal Information

Full Name

Date of Birth

Gender

Nationality

Passport/ID Number

Voyage Number / Ship Name

Cabin/Seat No.

Health Information

Have you experienced any of the following symptoms during the past 14 days?

- ☐ Fever
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ None of the above

Have you been in contact with anyone diagnosed or suspected of having a communicable illness in the last 14 days?

If yes, provide details

List countries/regions visited in the past 21 days

Declaration

☐ I declare that the information given above is true and complete to the best of my knowledge.

Date

Signature