Vessel Entry COVID-19 Health Screening Form

Full Name

Vessel Name

Rank/Position

Date of Entry

Contact Number

1. Symptoms (in the last 14 days)

☐ Fever ☐ Cough ☐ Sore Throat ☐ Shortness of Breath ☐ Loss of Smell or Taste ☐ None

2. Exposure History

Have you had close contact with a confirmed or suspected COVID-19 case in the last 14 days? ○ Yes ○ No

Countries or ports visited in the last 14 days

Additional Comments

Signature

Date