



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