

The undersigned acknowledge, that I will be responsible for the following:

- 1- Download the COVID-19 DXB application on my smart phone.
- 2- Self-quarantine at home or in an institute until I receive my COVID-19 PCR test result, and I will leave the quarantine only after I receive a normal COVID-19 test result.
- 3- If my test result was positive for COVID-19, I will isolate myself for 14 days and follow the instructions given to me by the Health Authority.
- 4- I will be responsible for all my actions and will comply with the preventive measures to help stop the spread of COVID-19.

I declare that I will take full responsibility for my actions,  
and that I may face legal actions if I don't follow the preventive measures  
expected from me, in accordance with the UAE law.

اتعهد أنا الموقع ادناه بـ :

- 1- تحميل تطبيق كوفيد 19 ، والالتزام بالحجر الصحي حتي استلام النتيجة.
- 2- الالتزام بالعزل الصحي لمدة 14 يوماً في حال كانت النتيجة إيجابية.
- 3- التعاون مع السلطات المختصة فيما يخص المعلومات أعلاه واي توجيهات تصدر في هذا الشأن.
- 4- الالتزام بجميع الأوامر والضوابط والتوجيهات والتدابير الوقائية الصادرة بشأن كوفيد 19.

كما انني اتحمل المسؤولية القانونية بحال مخالفتي ذلك وفقاً لقوانين  
دولة الإمارات العربية المتحدة.

الاسم الكامل / Full name

.....

الجنسية  
Nationality

رقم الجواز / الهوية  
Passports / EID

.....

عنوان السكن  
Address

مغادر من  
Departure from

.....

هاتف المنزل  
Home number

رقم الهاتف المتحرك  
Mobile

.....

البريد الإلكتروني  
e-mail

رقم احد الأقارب أو الكفيل  
Sponsor

.....

التاريخ / Date

التوقيع / signature

.....

لتحميل البرنامج  
Download the app



### Health Declaration Form

To protect your health, public health officers need you to complete this form. Your information would help public health officers to contact you if you were exposed to a communicable disease. It is important to fill out this form completely and accurately. Your information is intended to be held in accordance with applicable laws and used only for public health purposes.

First Name:	Surname:	Nationality:	Gender:
Emirates ID/Passport No.:	Date of Flight:	Flight Number:	Seat Number:
Airport of Departure:	Final Destination:	Contact Number:	Second Contact Number:
Address in the UAE Emirate of residence:	Area and street:	Hotel name or villa/flat number:	

1. Have you been diagnosed as COVID-19 (Novel Coronavirus) patient? if yes when:.....
2. Did you, in the past 14 days, come in close contact with someone who has been diagnosed with COVID-19? Yes/No
3. Have you had any fever or respiratory symptoms “coughing, sneezing, trouble breathing” in the past 3 days? Yes/No
4. Do you have health insurance valid in the UAE? Yes/No
5. Have you travelled to any other country in last 14 days? If yes please specify.....

“I hereby declare that I am fit to travel and confirm that I have filled the information required accurately and I have carefully considered the statements made above and that to the best of my knowledge are complete, correct and that I have not withheld any relevant medical information or made any misleading statements. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

**NAME:**

**SIGNATURE:**

**DATE:**