SELF-DECLARATION FORM

Personal Details			
Name		Age	
Designation		Department/ OU/ BU/Organization	
External Visit/ Meeting Related			
Person to Meet (Host)		Purpose	

Travel History (for the past 14 days)				
	*Travelled to Affected Country	YES / NO	*Have you been in close contact with suspected/confirmed case	YES / NO
1	Name of country and city travelled		Date of travel	
	Transit point (if applicable)		Date of return	
2	Name of country and city travelled		Date of travel	
	Transit point (if applicable)		Date of return	
Body Temperature				

* If **YES**, approval from GMD (Head Office)/ HOU/ HBU is required

I hereby declare that I am **FREE** from the following conditions/ symptoms:

Symptom	Yes	No	If No, please provide a details
Fever			
Cough			
Shortness of breath			
Runny nose			
Headache			
Sore throat			

I agree that the above information provided is, to the best of my knowledge, complete and true.

Name	Signature	Position	Date

Acknowledge by Host:

Name	Signature	Position	Date
Comments *(if any)*:			