Date of Issue: _____

COVID-19 TRAVEL MEDICAL CERTIFICATE

Patient Name:

Patient Passport Number:

To Whom It May Concern:

_____has tested NEGATIVE for COVID-19 using a PCR swab test.

The negative results were Issued to the patient on____.

The patient is not displaying any signs or symptoms associated with COVID-19.

Doctor's Name:

Doctor's Signature:

Clinic Name and Contact Information:

_____

_____

_____

Doctor/Clinic Stamp:

Important:

***Must be original - NOT a copy**

***Printed on official clinic letterhead**

***Signatures in original ink – preferably not black ink**

***Accompanied by signed & stamped lab results**