



**The Republic of Namibia**  
**MINISTRY OF HEALTH AND SOCIAL SERVICES**

**HEALTH QUESTIONNAIRE FOR TOURISM REVIVAL INITIATIVE TRAVELERS**

(This questionnaire must be completed by all incoming travellers prior to departure)

Expected date of Arrival: \_\_\_\_\_

Flight No: \_\_\_\_\_ Seat No: \_\_\_\_\_

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Passport No: \_\_\_\_\_

Nationality: \_\_\_\_\_

Gender: \_\_\_\_\_ Age \_\_\_\_\_

Country of Departure, including connection stops before this trip: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Envisaged Destination in Namibia (Please list all destinations, with name of town and hotel): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Intended length of stay in Namibia: \_\_\_\_\_ (Days)

Within the past 14 days have you ever been to any of the COVID-19 affected country/area?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which country/area? Please specify

Within the past 14 days have you had close contact with or cared for someone who has been diagnosed with COVID-19?

\_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any of the following signs or symptoms?

(Tick as appropriate)

Symptoms	Yes	No	Unknown
Fever			
Cough			
Chills or rigors			
Sore throat			
Shortness of breath			
Runny nose			
Headache			
Fatigue/feeling tired			
Loss of taste/smell			
Muscle pain			
Joint Pain			
Nausea			
Chest pain			
Other symptoms			

I \_\_\_\_\_ Pledge to obey all the COVID-19 Health Regulations of the Republic of Namibia.

Date: \_\_\_\_\_

Signature \_\_\_\_\_

Please go to the nearest Health facility or call the toll-free number 0800100100, should you experience any of the above-mentioned symptoms.