**Annex “A2”**



**2020 Physician Licensure Exam** **/QA-FMP**

HEALTH DECLARATION CHECKLIST

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| **IMPORTANT REMINDER: *The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential.*** |

*FILL OUT ENTRIES IN BOLD LETTERS*

**Personal Data:**

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

*Last Name First Name Middle Name*

Sex: [ ] Female Age: \_\_\_\_\_\_\_

[ ] Male

Contact Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(HOUSE NO. & STREET) (BARANGAY) (TOWN/DISTRICT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(CITY/PROVINCE) (COUNTRY/STATE) (POSTAL/ZIP CODE)

Mobile No/ Telephone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applicable)

**Please check if you have any of the following at present or during the past 14 days:**

[ ] Fever ≥ 37.50C (oral temperature) [ ] Cough [ ] Diarrhea

[ ] Headache [ ] Fatigue [ ] Nausea/Vomiting

[ ] Sore Throat [ ] Body Aches [ ] Body Weakness

[ ] Difficulty or [ ] Loss of Taste or Smell [ ]Runny Nose

Shortness of Breath

**Please enumerate, if any, cities in the Philippines you have worked, lived, transited in the past 14 days.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please enumerate, if any, foreign countries you have worked, lived, transited in the past 14 days. \_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Please check the appropriate box***

**YES NO**

Did you visit any health worker, hospital, or clinic during the past 14 days? [ ] [ ]

Were you confined in a hospital or clinic during the past 14 days? [ ] [ ]

Do you have anyone such as household member/s or close contact/s who [ ] [ ]

are currently having fever, cough and/or respiratory problems?

In the last 14 days, have you been in close contact or exposed to any [ ] [ ]

person suspected of COVID-19?

Have you been in Face-to-face contact with a confirmed case within [ ] [ ]

1 meter and for more than 15 minutes

In the last 14 days, have you been in contact with a person confirmed [ ] [ ]

with COVID-19?

When did this person or contact receive a positive RT-PCR test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you undergone any test for SARS-Cov2 for the past 14 days?** [ ] [ ]

Test Type: RT-PCR Rapid Serology Antibody Test

Cartridge-based PCR Rapid Antigen Test

Rapid ECLIA Antibody Test Others, specify: \_\_\_\_\_\_\_\_\_\_\_\_

Results: Positive Negative Reactive Non-reactive

Sample Unfit for Testing Pending

Where was the test done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Do NOT write below this line)

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***TO BE ACCOMPLISHED BY PRC REPRESENTATIVE AND/OR ASSIGNED MEDICAL STAFF***

**Results of the RT-PCR Test Required by PRC:** [ ] Positive [ ] Negative

Date of Release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note/Observations, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IF DONE, THE ORIGINAL OFFICIAL RESULT OF RT-PCR SHOULD BE ATTACHED TO THIS FORM. IN LIEU OF THE RT-PCR, A CERTIFICATE OF QUARANTINE OR ITS EQUIVALENT SIGNED BY THE ACCREDITED LICENSED PHYSICIAN OR DULY AUTHORIZED LOCAL OFFICIAL SHOULD BE ATTACHED/SUBMITTED.***

***Declaration and Data Privacy Consent Form***

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| --- |
| *I submit that the information I have given is true, correct, and complete. I understand that my failure to answer any question, or any misrepresentation of facts or false/misleading information given by me may be used as a ground for the filing of cases against me in accordance with law. I voluntarily and freely consent to the collection and processing of the above personal information only in relation to the IATF Resolution No. 58, series of 2020, pertinent DOH directives, and PRC health and safety protocols.*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Name and Signature Date  *Please be advised that the above information shall only be used in relation to the aforementioned protocols in accordance with the Data Privacy Act and Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act.* |

**Verified by** *(PRC Representative/Proctor)***:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature above Printed Name