



Ministry of Health Malaysia

**HEALTH DECLARATION FORM
FOR PASSENGERS ON BOARD**

Ladies and Gentlemen,

Welcome to Malaysia.

Malaysia is taking all the necessary precautionary measures against the spread of COVID-19 infection into our country.

If you have travelled or stayed in affected countries over the past fourteen (14) days, you are kindly requested to declare your health status on the overleaf of this card as required under Section 15 of the *Prevention and Control of Infectious Diseases Act 1988* [Act 342]. Any person who refuses to furnish any information under this Act or gives false information, commits an offence and if found guilty shall be punished with imprisonment or fine or with both.

The Ministry of Health Malaysia values your sincere cooperation in this matter.

Thank You.

Director General of Health
Ministry of Health Malaysia

Disease Control Division, Ministry of Health Malaysia,
Level 3, 4, 6, Block E10, Federal Government Administration Centre,
Parcel E, 62590 Putrajaya
Tel: 03-8000 8000 Fax no: 03-8888 0643

PUBLIC HEALTH COVID-19 HEALTH DECLARATION FORM

All person entering Malaysia shall complete all the information required in this Form

PART A (General)

1. Full name:
(Use block letters)

2. Gender: Male Female

3. Age (year/month):

4. Passport Number:

5. Nationality:

6. Identity Card No:.....

7. Mode of Transport: Air Sea Land

8. Flight No./Vehicle Registration No./Name of Ship/Name of Train:

.....

9. Seat No. (if applicable):

10. Last Place of Embarkation:

11. Address in Malaysia:

.....

12. Telephone No.

House:

Office:.....

Mobile:.....

**PART B
COVID-19**

1. Have you been to any area or countries of COVID-19 as indicated by WHO over the past 14 days?

Yes No

2. Date of departure from the said country:

3. Have you had any of the following symptoms over the past 14 days? Please tick if yes

Fever	<input type="checkbox"/>
Cough	<input type="checkbox"/>
Difficulty in breathing	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>
Sudden loss of sense of taste or smell	<input type="checkbox"/>

Other symptoms (please specify):
.....

Have you been in ¹close contact with person suspected to have COVID-19?

Yes No

If the answer is yes to either of the question above, please report to the Health Screening Area.

4. Please indicate all countries and cities that you have visited or transited through in the last 14 days (including airport, ports and border crossing), providing the dates of the visit. List the most recent countries first.

¹Definition close contact :

- Health care associated exposure, including providing direct care for COVID-19 patients, working with health care workers infected with COVID-19, visiting patients or staying in the same close environment of a COVID-19 patient.
- Working together in close proximity or sharing the same classroom environment with a COVID-19 patient
- Traveling together with COVID-19 patient in any kind of conveyance
- Living in the same household as a COVID-19 patient

Signature:.....

Date :.....