



LOW RISK COUNTRIES Public Health Passenger Locator Card (PLC): To protect your health, public health officers need you to complete this form whenever they suspect a communicable disease onboard a flight. Your information will help public health officers to contact you if you were exposed to a communicable disease. It is important to fill out this form completely and accurately. Your information is intended to be held in accordance with applicable laws and used only for public health purposes

~Thank you for helping us to **protect your health.**

One form should be completed by EACH PERSON. Parents should complete this form for the minors. Print in capital (UPPERCASE) letters.

FLIGHT INFORMATION:

1. Airline name 2. Flight number 3. Seat number 4. Date of arrival (yyyy/mm/dd)

PERSONAL INFORMATION:

5. Last (Family) Name 6. First (Given) Name 7. DATE OF BIRTH 8. Your sex Male Female

TEMPORARY (DESTINATION) PHONE NUMBER(S) where you can be reached if needed.

9. Mobile 10. Business
 11. Home 12. Other
 13. Email address

TEMPORARY (DESTINATION) ADDRESS

14. Street/ Hotel House/ApPt #

HEALTH INFORMATION

15. HAVE YOU TRAVELED ABROAD FOR THE LAST 14 DAYS?
 YES: NO:

15A HAVE YOU BEEN IN CONTACT WITH A CONFIRMED CASE OF COVID-19?
 YES: NO: MAYBE:

16. IF SO, WHICH COUNTRIES DID YOU VISIT?

17. DO YOU HAVE A MEDICAL INSURANCE?
 YES: NO:

17A MEDICAL INSURANCE COMPANY 'S NAME:

EMERGENCY CONTACT INFORMATION of someone who can reach you during the next 30 days

18. Last (Family) Name 19. First (Given) Name 20. City
 21. Country 22. E-mail
 23. Mobile phone 24. Other phone

25. TRAVEL COMPANIONS – FAMILY and non-Family:

	Last (Family) Name	First (Given) Name	Seat number	Age
(1)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

26. I HAVE THE FOLLOWING COVID-19 SYMPTOMS:

COUGH: Y/N FEVER/CHILLS: Y/N LOST OF TASTE OR SMELL: Y/N SORE THROAT: Y/N CONGESTION and OR RUNNY NOSE: Y/N

I HEREBY DECLARE THAT I HAVE TRUTHFULLY COMPLETED THIS FORM AND I UNDERSTAND THAT I AM LIABLE FOR ALL MEDICAL COSTS FOR MYSELF AND OR FOR MY FAMILY MEMBERS WHILE I

AM/WE ARE IN CURACAO _____
 SIGNED BY: _____

- A) You must submit this form 48 hours before departure to travelhistory.epi@gobiernu.cw.
- B) On arrival you should submit a hard copy of this form to the immigration officer.