## FOR THE BES ISLANDS, SINT MAARTEN AND ARUBA

**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) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |

26. I HAVE THE FOLLOWING COVID-19 SYMPTOMS:

COUGH: ☐ FEVER/CHILLS : ☐ LOST OF TASTE OR SMELL: ☐ SORE THROAT: ☐ CONGESTION OR RUNNY NOSE: ☐

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I HEREBY DECLARE THAT I HAVE TRUTHFULLY COMPLETED THIS FORM AND I UNDERSTAND THAT I AM RELIABLE FOR ALL MEDICAL COST FOR MYSELF

AND OR FOR MY FAMILY MEMBERS WHILE I AM/WE ARE IN CURACAO_____

SIGNED BY: _____

Write/*Print in capital (UPPERCASE) letters*

IT IS MANDATORY TO SUBMIT THIS FORM BEFORE DEPARTURE TO travelhistory.epi@gobiernu.cw AND HAND OVER THIS FORM IN HARD COPY ON ARRIVAL AT THE IMMIGRATION