Visitor Registration & Health Declaration Form

Visitor Information

Full Name*

Contact Number*

Email Address

Company/Organization

Purpose of Visit*

Date of Visit*

Person/Department to Visit

Health Declaration

In the past 14 days, have you experienced any of the following symptoms? (Tick all that apply)

- [ ] Fever
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Sore Throat
- [ ] None

Have you been in contact with any confirmed/suspected cases of infectious diseases (e.g., COVID-19) in the last 14 days?

--Select--

Have you traveled internationally or to any high-risk area in the last 14 days?

--Select--

I hereby declare that the information provided above is true and correct to the best of my knowledge.

Submit Registration