HEALTH DECLARATION FORM

Please declare whether you have the following diseases/ conditions;

- Mention as **Yes** if you have the following diseases/ conditions
- Mention as **No** if you do not have the following diseases/ conditions

Disease/ conditions	**Self-Declaration**		**If Yes, please provide details**
	Yes	**No**	
Chronic Kidney Disease			
Cancer			
Filaria			
Hepatitis B			
Hepatitis C			
HIV			
Malaria			
Other illness which need long-term medical treatment			
Tuberculosis			

Are you from a country where, Yellow Fever is endemic? Yes/No

If Yes, Have you received the vaccine for Yellow Fever?

Are you from a country where, Malaria is endemic? Yes/No

Were you been positive for COVID 19? Yes/No

If Yes, when?

Have you received vaccination for COVID 19? Yes/No

If Yes, please provide vaccination details;

I am aware that, I have to bear all the expenses related to medical management, if I am diagnosed with any medical condition unless I am a Sri Lankan Citizen.

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

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Date (dd/mm/yyyy) **Name of the applicant as indicated in the passport**

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Applicant's signature **Applicant's passport number**

Kindly ensure all the information requested in this form is completed in English Language.