**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 / Condition** | **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

……………………………………………………

Applicant’s passport number

…………………………………………………..

Name of the applicant as indicated in the passport

………………………………..

Date (dd/mm/yyyy)

………………………………..

Applicant’s signature

Kindly ensure all the information required in the form is completed in English Language