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

…….. ……..

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

…….. ……

Applicant's signature Applicant's passport number

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