

Medical Certificate - SARS-CoV-2 testing result

This is to certify that:

Name:
Current Address:
Country of residence:

Has been tested for the presence
of SARS-CoV-2 on:

Date:
Time:

Status report of infection
on the date of the test:

Date of report:	
Testing result: Neg:	Pos:

Date:	Signature and seal of the certifying medical doctor:
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Date:	Signature:
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