

Name)

FULL NAME (Surname, First Name, Middle

Republic of the Philippines Department of Environment and Natural Resources XI **Mount Hamiguitan Range Wildlife Sanctuary**

PROTECTED AREA MANAGEMENT OFFICE PENRO Davao Oriental, Gov't Center, Mati, Davao Oriental Tel. No.: (+63) (087) 388-3275 (PENRO);

Email: hamiguitan.protect@gmail.com



TEMPERATURE

UNESCO World Heritage Site & ASEAN Heritage Park

ARRIVAL HEALTH DECLARATION FORM

IMPORTANT NOTE: Due to the threat of the COVID-19 pandemic and pursuant to the set guidelines recommended by the Inter-Agency Task Force against COVID-19, the Protected Area Management Office of Mount Hamiguitan Range Wildlife Sanctuary, in collaboration with the straddled LGUs of the protected area, comply with the government directive related to travel restrictions due to the current health situation.

Relative to this, as our guest/client, may we require you to fill out this form truthfully, to be attached with a copy of your valid Identification Card. Kindly write legibly. If the item is not applicable in your case, please put 'N/A' in the space provided after. Tick a check mark on items with the correct answer of your choice.

GENDER

NATIONALITY

| CONTACT DETAILS | | Mobile/ Telephone No. | E-mail | | | | |
|--|---|---|---|-------------------------|---------------------|--|--|
| TYPE OF ID PRESEN | NTED WITH ID NO. | | | | | | |
| Local destination/s v Have you visited a H Have you ingested at Have you visited ab | he past two (2) weeks isited in the past two (2) we ospital or Clinic in the past ny medication for fever in to y poultry farm or animal ma- ide the following signs and | two (2) weeks? [the last four to six arket in the past for |] YES [] NO (4-6) hours? [] ourteen (14) days | YES []NO s?[]YES[]NO | fourteen (14) days. | | |
| | [] Headache | [] Difficulty in breathing | | | | | |
| | [] Cough | | [] Body Weakness | | | | |
| [] Cold | | [] Unexpected Bruising or bleeding | | | | | |
| | [] Sore Throat | nedication? [] V | | Others (please spec | ify): | | |
| | allergy from any food or n | | | | | | |
| If YES, please specif | | | | | | | |
| If YES, please specif | y:above information true and | | | | te | | |
| If YES, please specifing I hereby declare the a Signature above | y:above information true and | correct. | | Da | te | | |



Republic of the Philippines

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| FULL NAME (Surname, First Name, Middle | AGE | GENDER | NATIONALITY | TEMPERATURE | |
|---|--|-----------------------------|----------------------|---------------------|--|
| Name) | | | | | |
| | | | | | |
| COMPLETE DECENT ADDRECS | | | | | |
| COMPLETE PRESENT ADDRESS | | | | | |
| CONTACT DETAILS | Mobile/ | E-mail | | | |
| CONTACT DETAILS | Telephone | E-man | | | |
| | No. | | | | |
| TYPE OF ID PRESENTED WITH ID NO. | | | | | |
| THE OF IS TRESENTED WITH IS NOT | | | | | |
| . Countries visited in the past two (2) weeks | 1 | | | | |
| Local destination/s visited in the past two (2) we Have you visited a Hospital or Clinic in the past | eks | IVES LINO | | | |
| Have you ingested any medication for fever in the | | | | | |
| Have you visited aby poultry farm or animal ma | | | | | |
| . Put a check mark beside the following signs and | symptoms IF yo | u EXPÈRÍEN | CED them in the past | fourteen (14) days. | |
| [] Headache | [] Difficulty in breathing | | | | |
| [] Cough | | [] | Body Weakness | | |
| [] Cold | [] Unexpected Bruising or | | | g or bleeding | |
| [] Sore Throat | | [] Others (please specify): | | | |
| | pecific allergy from any food or medication? [] YES [] NO specify: | | | | |
| I hereby declare the above information true and o | correct. | | | | |
| | | | | | |
| Signature above Printed Name | | | Dat | e | |
| =====TO BE FILLED OUT | BY MHRWS-P | AMO===== | | | |
| RECEIVED BY: DATE: | SIC | NATURE: | | | |