MINISTRY OF HEALTH AND MEDICAL SERCIVES

SWAB TEST APPROVAL FORM

Applicant Name (in full): _____

Passport Number: _____

Date of Travel: _____

Reason for requesting SWAB TEST: _____

_____

☐ **Approved** ☐ **Not Approved**

_____ **Date:** _____

Acting Permanent Secretary.

OFFICIAL USE ONLY

The Cashier – Accounts Section.

Amount paid: _____

Receipt No: _____ **(Always attached a copy of receipt with this application form)**

Date (payment received): _____

Signature of Cashier: _____

Officer in Charge of Swab Test: _____

Collection date for swab result: _____

Mode of collection:

☐ Personal Collection ☐ Email ☐ Postal Address.

_____ Date: _____

Signature of Officer: