STARCITY

Move in Declaration

Name:	
Building & Room No.	
Nationality:	
Your NRC / Passport:	
Mobile Number, E-mail :	

Travel Declaration

1. Have you travelled abroad (i.e. to any countries outside of Myanmar) in the past 14 days?

Yes ☐ **No** ☐
If yes, Please declare the country _____.

2. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?

Yes ☐ **No** ☐

3. Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing?

Yes ☐ **No** ☐
If 'Yes', please declare where did you go and take proper treatment e.g. hospital name_____.

I hereby declare that the information given is true, correct and complete. I understand that I am solely responsible for any willful omission in filling this form.

If the answer is 'Yes' to any of the questions you are required to seek medical assistance before access to the facility can be granted.

Sign :
Date :