

UNITED STATES TRAVELER HEALTH DECLARATION FOR REPATRIATION FLIGHTS

Providing the following information to the Centers for Disease Control and Prevention is authorized under Title 42 Code of Federal Regulations Section 71.20, and is being collected as part of the public health response to 2019 Novel Coronavirus (COVID-2019). The information will be used by U.S. public health authorities and other international, federal, state, or local agencies for public health purposes.

Each traveler needs a separate form.

Family name: First (given) names:

Citizenship:..... Country of residence:

Birth date: ___/___/___ (Day/Month/Year) Sex: Male Female

Date of US arrival: ___/___/___ (Day/Month/Year) Seat number(s) on plane:

Final destination address:
City:

State/Province: Country:E-mail address:

Do you have a US mobile phone? Yes No US mobile number:

TODAY OR IN THE PAST 72 HOURS (3 DAYS), HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

Fever (100.4° F / 38° C or higher), felt feverish, or had chills?

Cough?

Difficulty breathing?

	YES	NO
Fever (100.4° F / 38° C or higher), felt feverish, or had chills?		
Cough?		
Difficulty breathing?		
	YES	NO
Worked as a health care provider in Hubei Province?		
Worked in a health care facility in Hubei Province but not as a healthcare provider?		
Visited a health care facility in Hubei Province?		
Were a patient in a health care facility in Hubei Province?		
Were around with someone sick with COVID-2019?		
Were around someone sick with fever AND cough or difficulty breathing in Hubei Province?		

IN THE PAST 14 DAYS, HAVE ANY OF THE FOLLOWING APPLIED TO YOU?

Worked as a health care provider in Hubei Province?

Worked in a health care facility in Hubei Province but not as a healthcare provider?

Visited a health care facility in Hubei Province?

Were a patient in a health care facility in Hubei Province?

Were around with someone sick with COVID-2019?

Were around someone sick with fever AND cough or difficulty breathing in Hubei Province?

Since 1 December, 2019, have you been diagnosed with COVID-2019 infection or pneumonia? Yes No

If yes, date of diagnosis: ___/___/___ (Day/Month/Year)

TO BE COMPLETED BY CENTERS FOR DISEASE CONTROL AND PREVENTION STAFF

First POE: Arrival Temp Visible signs of illness: Yes No Screener: _____
 Departure Temp Visible signs of illness: Yes No Screener: _____
Repatriation Center: Temp Visible signs of illness: Yes No Screener: _____

This data collection is mandatory. Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX.