

## UNITED STATES TRAVELER HEALTH DECLARATION FOR REPATRIATION (SHIP)

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.**

**Flight 1:** Number \_\_\_\_\_ Seat number \_\_\_\_\_  
**Flight 2:** Number \_\_\_\_\_ Seat number \_\_\_\_\_ (if needed)  
**Flight 3:** Number \_\_\_\_\_ Seat number \_\_\_\_\_ (if needed)

Family name: ..... First (given) names: .....  
 Citizenship:..... Country of residence: .....  
 Birth date: \_\_\_ / \_\_\_ / \_\_\_ (Day/Month/Year) Sex: Male  Female  Cabin number on ship:.....  
 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 24 HOURS 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
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

IN THE PAST 14 DAYS, DID YOU HAVE CLOSE CONTACT (WITHIN 6 FEET/2 METERS) OF A PERSON WITH COVID-2019?

YES  NO

If yes, date contact occurred: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Day/Month/Year)

Was this person your cabin mate on ship? YES  NO

### TO BE COMPLETED BY CENTERS FOR DISEASE CONTROL AND PREVENTION STAFF

Destination 1: Arrival Temp		Visible signs of illness: YES <input type="checkbox"/> NO <input type="checkbox"/>	Screener: _____
Destination 2: Arrival Temp		Visible signs of illness: YES <input type="checkbox"/> NO <input type="checkbox"/>	Screener: _____(if needed)
Destination 3: Arrival Temp		Visible signs of illness: YES <input type="checkbox"/> NO <input type="checkbox"/>	Screener: _____(if needed)

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.