

**إقرار وتعهد بالالتزام بإجراءات الحجر الصحي**

أنا الموقع أدناه أتعهد بأنه تم إبلاغي بالإجراءات الصحية والنصائح الطبية الواجب اتباعها، وأنتي أدرك المخاطر التي من الممكن أن تلحق بالمجتمع في حال عدم التزامي، لذا حرصا على الصحة العامة وتجنب المساءلة القانونية أتعهد بعدم مغادرة الحجر الصحي مع مراعاة تجنب مخالطة الآخرين قدر الإمكان حتى نهاية الإجراءات الصحية المطلوبة وفترة الحجر الصحي لمدة ١٤ يومًا اعتبارًا من التاريخ المحدد من قبل الجهة الصحية وذلك إقرارًا مني بأنه تم إخطاري بما ذكر أعلاه و تجنبًا للمساءلة القانونية في حال عدم التزامي بإجراءات الحجر الصحي.

الاسم :	رقم الجواز/ الهوية الوطنية:
رقم الهاتف المتحرك :	رقم الهاتف الثابت:
رقم أحد الأقارب أو الكفيل:	البريد الإلكتروني:
التوقيع:	التاريخ: / /

Undertaking to implement and adhere to the quarantine procedure

I undertake / declare that I was notified about the health procedures and the medical advices that I should follow, and that I am aware of the risks that could happen to the community in case I am not committed to those procedures, for the sake of public health and to avoid the legal accountability I hereby declare that I will not leave the quarantine and I will not get in contact with others until the required health measures are met. The duration of the quarantine is 14 days starting from the date identified by health authority

This is my acknowledgment that I have been notified of the above mentioned. and that failure to adhere to the procedure will subject me to legal action.

Name:	Passport / ID No:
Mobile number:	Home number:
Number of friend/sponsor/next of kin:	
Email address:	Signature:
Date: / /	



To protect your health, public health officers need you to complete this form. Your information would help public health officers to contact you if you were exposed to a communicable disease. It is important to fill out this form completely and accurately. Your information is intended to be held in accordance with applicable laws and used only for public health purposes.

WRITE CLEARLY AND IN BLOCK LETTERS

PERSONAL DATA

First Name: _____ Surname: _____
Nationality: _____ Gender: _____
DOB: _____ Emirates ID/Passport: _____
Contact Number: _____

EMPLOYMENT DATA

Job Category: _____ Employer/place of work: _____
Employer address and contact details: _____

ACCOMODATION DATA

Address in the United Arab Emirates: _____

Do you live in:

☐ Villa ☐ Flat ☐ Hotel ☐ Apartment

☐ Shared Accomodation ☐ Staff Accomodation

If shared accommodation, how many people are living in the same accommodation:

Do you have a separate toilet?

☐ Yes ☐ No

If required, are you able to self-isolate?

☐ Yes ☐ No

If YES, please specify: _____

If self isolation is required, can you fund your stay in isolation? (minimum \$50 per day)

☐ Yes ☐ No

If NO, please specify: _____



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MEDICAL DATA

Do you have a chronic medical condition such as diabetes, hypertension, cancer, immune compromising disorder?

☐ Yes ☐ No

If YES, please specify: _____

Are you currently on any medication?

☐ Yes ☐ No

If YES, please specify: _____

Do you have anyone living with you who is above 60 years of age?

☐ Yes ☐ No

Do you have anyone living with you who is suffering from low immunity or chronic disease (diabetes, hypertension, cancer, etc.)

☐ Yes ☐ No

If YES, please specify: _____

Do you have health insurance?

☐ Yes ☐ No

AGREEMENT

I understand that this form will be used for public health matters, and I confirm that I have filled the information required accurately

Name: _____

Signature: _____

Date: _____