

TURKISH REPUBLIC OF NORTHERN CYPRUS

**MINISTRY OF HEALTH**

**TRNC MINISTRY OF HEALTH INFORMATION AND OBLIGATION FORM**

**PERSONAL INFORMATION:**

NAME :

SURNAME :

DATE OF BIRTH:

I.D. NUMBER:

PASSPORT NO:

ADDRESS (FULL ADDRESS) :

RESIDENCE ADDRESS IN TRNC (FULL ADDRESS)  
PHONE NUMBER:

PHONE NUMBER THAT CAN BE REACHED IN TRNC:

**REASON FOR ARRIVING TO THE COUNTRY:**

HOLIDAY ( ) WORK ( ) EDUCATION ( ) FAMILY VISIT ( ) PERMANENT RESIDENCE TRNC ( )

**COUNTRIES VISITED IN THE LAST 15 DAYS:**

**NUMBER OF DAYS PLANNED TO STAY IN NORTHERN CYPRUS:**

**IF YOU HAVE PASSANGERS UNDER THE AGE OF 18 ACCOMPANYING YOUN:**  
  
NAME: NAME: NAME:   
AGE: AGE: AGE:

**COMMITMENTS**1- UNTIL I AM NOTIFIED ABOUT MY SARS-COVID 2 TESTS (PCR) NEGATIVE RESULTS THROUGH THE PHONE NUMBER AND ADDRESS I STATED ABOVE, I WILL BE SELF ISOLETED AND WILL NOT BE IN CONTACT WITH OTHERS AND IF MY TEST RESULTS ARE POSITIVE I DECLARE THAT I ACCEPT TO BE UNDER QUARANTINE BY THE TRNC LAW AND RULES.

2- EVEN IF I HAVE A NEGATIVE PCR TEST DONE WITHIN LAST 72 HOURS PRIOR TO MY TRIP,IF TRNC AUTHORITIES THINKS ITS NECCESSARY I PROMISE TO BE RE PCR TESTED AGAIN.

3- IF TRNC AUTHORITIES THINKS IT IS NECESARRY, I PROMISE TO BE UNDER QUARANTINE AND THE QURANTEENE FEES WILL BE COVERED BY ME.

4- I DECLARE THAT THE ABOVE INFORMATION I HAVE GIVEN IS CORRECTED AND I WILL FOLLOW THE TRNC LAWS FOR THE PERIOD I AM IN THE COUNTRY.

5- IF THE ABOVE INFORMATION IS NOT CORRECT OR IF I ACT CONTARARY TO MY PROMISSED ACTIONS I ACCEPT AND DECLARE FOR LEGAL ACTIONS TO BE TAKEN AGAINST ME.

6-DURING THE TIME I AM IN TRNC I WILL BE AWARE OF ALL THE RISKS OF EPIDEMIA, I WILL FOLLOW PUBLIC HEALTH MEASURES TAKEN, AND I PROMISE I WILL NOT REQUIRE ANY RIGHTS FOR THE LOSSES THAT ARE DUE TO EPIDEMIA.

7-I PROMISE TO INFORM TRNC MINISTRY OF HEALTH (arsiv.saglik@ gov.ct.tr) IF I EXPERIENCE ONE OF THE SYMPTHOMS RELATED TO COVID-19 SUCH AS HIGH FEVER, CAUGH, DIFFICULTY IN BREATHING,SORE THROAT, RUNNY NOISE, DIARRHEA, NAUSEA, VOMITTING,WEAKNES.

8-I DECLARE I HAVE NOT BEEN IN A COUNTRY EXCEPT THE COUNTRIES I DECLARED IN THE LAST 14 DAYS

9- IN THE LAST 14 DAYS, I HAVE NOT EXPERIENED ONE OF THE COMPLAINTS SUCH AS HIGH FEVER, CAUGH, DIFFICULTY IN BREATHING,SORE THROAT, RUNNY NOISE, DIARRHEA, NAUSEA, VOMITTING,WEAKNES, MUSCLE PAIN AND I AGREE THAT I HAVE NOT CONTACT WITH THE A POSSIBLE COVID-19 PATIENT IN THE LAST 14 DAYS, I HAVE NOT RECEIVED COVID-19 TREATMENT.

NAME-SURNAME :

DATE :

SIGNATURE :

IMPORTANT NOTE: FILL THIS FORM DURING FLIGHT, AND IF REQUESTED FROM YOU, YOU HAVE THE OBLIGATION TO DELIVER TO THE AUTHORITIES WITH YOUR PCR NEGATIVE TEST RESULTS