SELF DECLARATION FORM

Room No:-	
Arrival Time:-	
Arrival Date:-	
Temprature Reading:-	
Guest Name:-	
Age:-	
Gender:-	
Contact No:-	
Permanent Address:-	
E-mail ID (Optional):-	
Nationality:-	
Coming From (Destination Details:-	
Proceeding to (Destination Details and Mode of Transportation while returning)	
Purpose of Visit	
ID Proof Presented:-	
Travel History	

Have you been directly exposed to someone who is suspected of having or diagnosed with COVID-19?	Yes	No	I don't Know

Please select the symptoms you are experiencing (if any)

High Fever	Yes	No
Difficulty Breathing		
Cough		
Persistent Pain/ Pressure in Chest		
Body Ache		
Nasal Congestion		
Runny Nose		
Sore Throat		
Diarrhoea		
Others		

When did you start experiencing these symptoms	Date:-
Signature:-	