Certificate of antigenic testing for COVID-19

This document certifies the following result which has been confirmed by a qualitative antigenic COVID-19 test conducted with the sample taken from the person mentioned bellow

If you fill out this document by hand, print clearly

PHARMACY'S INFORMATION					
Pharmacy's complete name:					
Complete address	CIVIC NUMBER, STREET	CITY	ZIP CODE	PROVINCE	COUNTRY
Telephone number: (AREA CODE) (XXX-XXXX)					

HEALTHCARE PROFESSIONNAL'S INFORMATION
First and last name:
Title:

PATIENT'S INFORMATION
First and last name:
Date of birth (YYYY-MM-DD):

QUALITATIVE ANTIGEN TEST INFORMATION	
Name, model, manufacturer:	
Lot number:	Expiration date:

Reason for screening (ex.: travel, contact with confirmed case and asymptomatic, etc.): ______________________________

Travel destination (if applicable): ______________________________

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It is the traveller's responsibility to verify the testing requirements with the visited countries/states/provinces (including stopovers) as well as the airline. Some requirements for transit are applicable.

Qualitative antigenic COVID-19 test result

Positive ☐ Negative ☐

Date (YYYY-MM-DD) ______________________ Time AM/PM ______________________

In case of positive result, note that the patient has been referred to a COVID-19 testing clinic to perform a PCR test. Isolation is required until the PCR test result.

HEALTHCARE PROFESSIONNAL'S CERTIFICATION

Signature: ______________________ License Number: ______________________

Professional college: ______________________