

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 na	me:					
Complete address						
CI	IVIC NUMBER, STREET	CITY	ZIP CODE		COUNTRY	
Telephone number: (ARE	A CODE) (XXX-XXXX	()	'			
HEALTHCARE PROFESSIONNAL'S INFORMATION						
First and last name:						
Title:						
PATIENT'S INFORMATION						
First and last name:						
Date of birth (YYYY-MM-D	D):					
	QUALITAT	IVE ANTIGEN	TEST INFORMA	TION		
Name, model, manufactu	ırer:					
Lot number: Expiration date:						
Reason for screening (ex.	: travel, contact with	n confirmed cas	e and asymptomatic	, etc.):		
Travel destination (if appl	icable):					
It is the traveller's responsit stopovers) as well as the air	•			countries/states/pro	vinces (including	
Qualitative antigenic Co	OVID-19 test res	<u>ult</u>				
Positive Negati	ve					
Date (YYYY-MM-DD)		Time Af	Л/РМ			
In case of positive result, no Isolation is required until th		has been referr	ed to a COVID-19 tes	sting clinic to perforn	n a PCR test.	
	HEALTHCARE	PROFESSIO	NNAL'S CERTIFIC	ATION		
Signature:		License Number:				
Professional college:						