Ministry of Health & Human Services
COVID-19 Testing Registration Form

Date ____ # ____ Test Site: ____ Hospital No: ____
(Leave blank if not applicable)

Please fill form with complete and accurate information:

Last Name ____ First Name ____ Middle /Initial ____

Date of Birth (MM/DD/YYYY) ____ Age ____ Gender ○ Male ○ Female State/Hamlet ____

Name of Parent or Guardian if Under 18 ____

Phone Number ____ Work Place: ____ Ethnicity: ○ Not Hispanic/Latino ○ Hispanic/Latino

Nationality: ☐ Palauan ☐ Filipino ☐ Japanese ☐ American ☐ Chinese ☐ Other ____

Race: ☐ Pacific Islander ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Multiple Race

FOR OUTBOUND TESTING ONLY (Information provided must match passport details)

Passport No ____ Final Destination: (City, State) ____

Transit: ☐ Japan ☐ Guam ☐ Other ____

Airline: ☐ United Airlines ☐ China Airlines ☐ Other ____

Signature (Print and Sign): ____

I certify that my information is correct. I understand that a reprint due to my errors will cost an additional $5.50.

FOR OFFICAL USE ONLY (DO NOT WRITE BELOW THIS LINE)

Previously tested positive for COVID-19? ☐ YES ☐ NO If yes, When? ____

Test Criteria
○ Community Testing ○ Inbound
○ Day 5 (Case) ○ Outbound
○ Day 10 (Case) ○ Both IN/Outbound

Test Type:
○ Antigen
○ PCR
○ Other ____

Testing Cost ☐ Verbal =$25.00 ☐ Printed =$30.50 Time: ____

Screener: ____ Sample Collected by: ____