



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 =\$44.50 Printed =\$50.00 Time:

Screeener: Sample Collected by: