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PASSENGER INFORMATION FORM

NAME/LAST NAME		
PASSPORT NUMBER		
PHONE NUMBER OF THE PERSON WHO CAN BE REACHED TO CONTACT WITH YOU		
PHONE NUMBER		
FLIGHT NUMBER	SEAT NUMBER:	DATE :
ADDRESS IN TURKEY OR DESTINATION		
If you have one or more of the symptoms below, please tick them. <input type="checkbox"/> High Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Shortness of breath		
The countries you have been in the last 14 days:.....		
Have you had close contact with a patient who was suspected with COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
The information I declare is correct and belongs to me.		
Declaration Date:/.... / 2020	Signature	
Note: If it is understood that the information provided on the form is incorrect, legal remedies will be taken against the person who filled out the form.		