Form for Voluntary Reporting

**For your and others’ health, please fill in truthfully.**（\* required）

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Items** | **Details** | | | | | | | | |
| 1 | Name\* |  | | | | | | | | |
| 2 | Gender\* | □Male □Female | | | | | | | | |
| 3 | Phone No.\* |  | | | | | | | | |
| 4 | ID Type\* | □ID Card □Temporary ID Card □Military ID □Mainland Travel Permit for Hong Kong and Macao Residents □Mainland Travel Permit for Taiwan Residents □Passport □Others（Single Selection） | | | | | | | | |
| 5 | ID No.\* |  | | | | | | | | |
| 6 | Date of Birth\* | Date/Month/Year: | | | | | | | | |
| 7 | Address\* | District Street Community | | | | | | | | |
| Building and Room No.  (Detailed address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| 8 | Employer |  | | | | | | | | |
| 9 | Unified Social Credit Code of Employer |  | | | | | | | | |
| 10 | Currently in which City\* |  | | | | | | | | |
| 11 | Personnel Type \* | Visitor□ Returnee to Shenzhen□  Staying in Shenzhen□（Single selection） | | | | | | | | |
| 12 | In Self-  Quarantine | Yes □ No □ | | | | | | | | |
| 13 | Residence\* | Personal property□ Rented accommodation□ Lodging as a visitor□ Hotel□ Others□ （Single Selection） | | | | | | | | |
| 14 | Having the following symptoms | □Fever □Fatigue □Cough □Nasal congestion □Running nose  □Diarrhea □Breathing difficulties □Null  Detail：  Armpit temperature over 37.3℃：Yes□ No□ | | | | | | | | |
| 15 | Out-of-town trip since Jan.1, 2020 | Trip | Place of departure | Date of departure | Place of destination | Date of arrival | Means of transport (plane/train/vehicle/  boat/others) | Flight/train/license plate/seat Number | Number of days staying in the destination |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 16 | Exposure to confirmed or suspected cases | Name of confirmed/ suspected patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Duration of exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exposure description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| 17 | Have been examined in hospital | Yes □ No □ | | | | | | | | |
| 18 | Need consultation or help | Reason: □ Cannot find proper accommodation  □ In severe condition and in need of medical advice  □ Others\_\_\_\_\_\_\_\_ | | | | | | | | |

**I have read the matters listed in this form and I guarantee that the content is correct and true.**