JEZDECKÉ CENTRUM
Resort Zduchovice

Self reporting

Name ……..

Address: ……..

Date of birth: ……

E-mail:……

Phone number:……

I have clinical signs of respiratory disease infectious: YES / NO

Laboratory-confirmed COVID-19 disease: YES / NO

Certificate of vaccination: YES / NO

Date of last dose of vaccination ……

Date of last PCR or Antigen fast test on COVID 19 ……..

Date…… Signature ……