

Appendix D

Medical certificate

This is to certify that

Name.....

born on.....in.....

tested negative for SARS-CoV-2 on..... (date on which test was carried out)

at..... (time at which test was carried out):

by means of a molecular biological test (test carried out at the following clinic:

.....) or

by means of an antigen test, or

has recovered from being infected with SARS-CoV-2 and been free of the most recent case of infection since.....; or

was vaccinated with the vaccine.....on the following dates:

First dose on:

Second dose on:

....., on.....

place, date, signature and stamp of the certifying medical doctor