## [corona | covid-19]

Has been tested for the presence Status report of infection on the date of the test:  Date: Date of report:  Time: PCR testing result: Neg: Pos:  Date: Signature and seal of the certifying medical doctor:	Country of residence:  Has been tested for the presence of SARS-CoV-2 with a PCR test on:  Date:  Date of report:  PCR testing result: Neg: Pos:  Date:  Signature and seal of the certifying medical doctor:	Country of residence:  Has been tested for the presence of SARS-CoV-2 with a PCR test on:  Date:  Date of report:  PCR testing result: Neg: Pos:  Date:  Signature and seal of the certifying medical doctor:	Country of residence:  Has been tested for the presence on the date of the test:  Date:  Date:  Date of report:  PCR testing result: Neg: Pos:  Date:  Signature and seal of the certifying medical doctor:	Name:			
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