Taipei City Hospital______Branch
Application Form for Self-pay COVID-19 Test

Medical Record No.：
Name：
Bed No.：

Please check the information on the documents for your travels (R.O.C passport, foreign passport), and fill in the following form. Please make sure the information that you provide (Name, ID number, and nationality) are correct, as they will help us issue accurate report and the diagnosis certificate.

Application Type：☐Urgent case (NT$4500) ☐Regular case (NT$3500)

Name of Applicant：______________________________；Gender：☐ Male ☐ Female

Date of Birth（DD/MM/YYYY）：________/________/________

Country of Citizenship：________________________

Identification No./Resident Permit No.：______________________________ (Either one)

Passport Name：____ (Required for departure)

Passport No.：____ (Required for departure)

Reason of Application：

☐Person under home(self) isolation/quarantine who need to go out for compassionate reasons, including visiting relatives in a critical condition, attending funerals of relatives, or dealing with other urgent issues.
☐To enter other countries for the compassionate reasons listed above.
☐Job requirements
☐Study Abroad
☐Departure from foreign countries, China, Hong Kong, or Macao
☐Family members of relevant departure applicable people
☐Agreed by the Central Epidemic Command Center for COVID-19
☐Other Reasons：____

Departure Date：（DD/MM/YYYY）：________/________/________

Flight No.：____

Time and other requirements to obtain the test result：______________________________

Sample Collection Date：（DD/MM/YYYY）：________/________/________

Signature of Recipient：____

Report Pickup Date：（DD/MM/YYYY）：________/________/________

Consent matters:

The applicant accepts the self-pay COVID-19 test from Taipei City Hospital, and also agrees to provide personal information including name, National ID No., date of birth, and test result to Ministry of Health and Welfare Taiwan Centers for Disease Control and National Health Insurance Administration. The information will be uploaded into the applicant's account on the Health Bank and the National Health Insurance Cloud System.

Signature of Applicant/Legal representative：___________________________

Telephone No.：_____________________________

Address：____

Emergency Contact person：_________________________________

Emergency Contact Telephone No.：_____________________________

Date（DD/MM/YYYY）：________/________/________