<CLINIC TO INSERT OWN LOGO>

**MEMO ON CONFIRMED COVID-19 INFECTION**

|  |  |
| --- | --- |
| **Full Name:**(As per NRIC/FIN/ Passport) |  |
| **NRIC/FIN/Passport:**  |  |
| **Country of Passport Issue:** (only if Passport No. provided) |  |

To whom it may concern,

 This is to certify that the abovementioned patient tested positive for SARS-CoV-2 (COVID-19) on \_\_\_\_\_\_\_\_\_\_\_\_<insert date> through a positive clinic administered ART test.

2. For further details, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ <insert name of clinic (and branch if applicable), email, phone number>.

Thank you.

|  |
| --- |
| **Stamp/ Signature/ Date** |

**Name:**

**Designation:**

**Clinic Name (and Branch if applicable):**