Annex 2

Sample of the medical certificate of the suffered COVID-19

(Name and address of the medical facility)

(Title, name and surname of the doctor who issued the certificate and who works in the Czech Republic or in another EU member state)

I confirm that ________________________ (name and surname), born on __________ (date of birth), residing at ______________________________ (address of the permanent residence) has no clinical signs of COVID-19, has been shown to have the disease COVID-19 and has undergone isolation to the extent specified in accordance with the applicable extraordinary measures of the Ministry of Health or the measures of another Member State of the European Union due to a positive RT-PCR test performed on ____________ (date).

In ________(city) ______ (date)

Doctor´s signature