

**Anlage D**

**Medical Certificate**

This is to certify that

name.....

born..... in.....

on the..... (date of sampling)

at..... (time of sampling)

has been tested negativly for the presence of SARS-CoV-2:

- molecularbiologically
- with an antigen test
- of a current infection with SARS-CoV-2 since  
.....recovered; or

has been vaccinated with the vaccine ..... on the following dates:

First vaccination on: .....

Second vaccination on: .....

....., On.....  
place, date, signature and seal of the certifying medical doctor