**[Vaccination record confirmation]**

To whom it may concern:

This health institution, _____ (name of health institution), hereby certifies that the following named person has completed a COVID-19 vaccination course. Details are as follows:

**Name of fully vaccinated person:**

**Passport No.:**

First dose

| | |
|---|---|
| Vaccine Name | |
| Vaccination Date | |

Second dose (if applicable)

| | |
|---|---|
| Vaccine Name | |
| Vaccination Date | |

Signature _____

Name of person-in-charge _____

Position of person-in-charge _____

Organisation chop _____