


Worker Identification			Delivery Location		Receiver Name + Phone Person responsible for distribution of labels at border workplace	
Last Name	First Name	DOB	Facility Name	Location	Name	Phone

Signed:

Instructions

1. Download this form
2. Fill out this form either
 - Print and fill out manually.
 - Or digitally with  Adobe Acrobat
3. Send completed form to covid19saliva@aphg.co.nz