Request for Issuance of a Certificate of approval for free rapid antigen tests for COVID-19 by way of exception for persons for whom due to medical reasons COVID 19 vaccination has not been recommended

PART I: PERSONAL AND RELEVANT MEDICAL DETAILS OF APPLICANT

Cypriot Identity Card Number/ Alien Registration Number (ARC)

Type of Registration: (Cypriot Identity Card/ ARC)

Full name exactly as written on the identity form:

Date of Birth (Day/Month/Year):

Mobile telephone number with the international country code:

Home address:

City/District/Community: Postal Code:

PART II: MEDICAL DETAILS OF APPLICANT

Reason for request for a certificate of approval for free rapid antigen tests for COVID-19 by way of exception for persons for whom due to medical reasons COVID-19 vaccination has not been recommended:

Valid period of time for access by way of exception From: / / Until: / /

Attached forms with scientific data justifying the above reason (medical opinions from specialist doctors, laboratory results, diagnostic tests):

PART III: RESPONSIBLE DECLARATION/AUTHORISATION

I declare having in mind the full provisions of the Law that:

1. The above details are true and that the attached documents are authentic

2. I hereby authorise documentation, processing and storing of data contained in my application in the software systems of the Ministry of Health:
   i. Documentation on the software system of requests for a certificate of approval for free rapid antigen tests for COVID-19 by way of exception for persons for whom due to medical reasons vaccination for COVID-19 has not been recommended.
   ii. Documentation on the software system of results of rapid antigen tests for COVID-19
3. I understand that the above details and actions concerning me and the above information given to the Ministry of Health are necessary for examination of my application.
4. In the event of withdrawal of this authorisation, I am obliged to directly inform the Permanent Secretary of the Ministry of Health.

Within the context of examination of my application, I hereby authorise the Ministry of Health and the constituted Committee for the Examination of Applications to:

A. Verify in cooperation with other Competent Government Authorities, medical officers, diagnostic centres, medical centres, health care units, organisations, authoritative bodies, other States the information contained in my application as far as this is deemed necessary.
B. Communicate with any medical officer, diagnostic centre/medical centre/health care unit/organisation/authoritative bodies/other States, considered appropriate in order to obtain further information or clarification necessary to examine my application.

PART IV: PERSONAL DATA

The contents of the this document is governed by the provisions of the Regulation (EE) 2016/679 of the European Parliament and of the Council of April 27th 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulations) and « the Regulation on the Protection of Natural Persons with regard to the Processing of Personal Data and on the Free Movement of such Data of 2018 (N.125(1)/2018)».

PART V: Submission

Applications must be sent to the email address vacexceptcertificcate@mphs.moh.gov.cy and they must include the following:

1. this document completed correctly
2. scanned supporting documents referred to in PART III (medical opinions from specialist doctors, laboratory results, tests from diagnostic centres)

Full name of applicant: **Signature:**

Date of completion of application: