STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

COVID-19 Testing Voucher

This test voucher is for a traveler to the state of Alaska, pursuant to Health Mandate 010 and the Alaska Chief Medical Officer's standing authority from the Extending COVID 19 Emergency Declaration/Relief Act, sec. 4 ch. 10, SLA 2020.

This is an order for the traveler to obtain a SARS-CoV-2 PCR test to be performed between day 7 and 14 after arrival to Alaska. Each voucher is good for one person and for one test.

To the traveler: Please visit the Alaska COVID-19 testing web page at http://dhss.alaska.gov/dph/Epi/id/Pages/COVID-19/testing.aspx to locate a testing site. Please look closely to see if a testing voucher is accepted at the location you choose to get tested. Each testing location has its own hours and practice. It is your responsibility to find a testing location that will accept this voucher. The testing location may ask for and bill your insurance, but you should not be charged a copay or assessment fee. Please remember that a test is not protective or curative and there can be false negatives. The reason for the second test, separated by time, is that it greatly improves the chance of detecting the virus that causes COVID-19. Until you receive your second test results, we ask that you minimize all exposure including going into indoor spaces such as stores and restaurants. Please enjoy Alaska while keeping Alaskans safe.

To the testing site: Please collect this voucher. You can also collect additional information such as insurance information as needed. Please use your normal process to contact the traveler with results. This voucher should be submitted to traveler@alaska.gov.

PARTICIPANT INFORMATION

First and Last Name _____

Gender ☐ Male ☐ Female ☐ Other: _____

Date of Birth _____

Mailing Address _____

City _____ State: Zip: _____

Physical Address while in Alaska _____

City _____ State: Zip: _____

Intended Duration of Stay in Alaska after today _____

Phone Number while in Alaska _____ Other Phone: _____

Race (Check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Decline

Participant signature _____

PARENT/GUARDIAN INFORMATION FOR MINORS

Parent/Guardian First and Last Name: Contact Phone:

Lab	Collection Site	Additional Purpose of Visit:
☐ **COVID-19 (IEN 1081)**		☐ Referred to Healthcare Provider for COVID-19 Symptoms

Provider Name (print): _____

Provider Signature: _____ **Date:** _____

Facility: _____