



**Confirmation Letter
Ministry of Public Health
Wellness Quarantine (WQ)**

DHSS/WQ 1

Patient/Customer's Name: **Passport No:**

Nationality: **Sex:** Male Female

Departure Country:

Please Check: **Name of Land Checkpoint:**

Name of Airline:..... **Flight No:**.....

Date of Arrival:.....

Date of Admission:.....**Date of Discharge:**.....

Accommodation in Thailand:.....

This is to certify that the above Customer has been accepted for treatment and/or medical procedures under my attendance during the period described below.

The conditions to be treated and the procedures are:

Please Check: Medical Spa/Wellness Resort/Spa Resort

Long Term Care

Planned procedures:.....

Treatment period:.....

Name of Health Establishments:.....

Address:..... T

Telephone:..... **Fax:**.....

Name of Attending Physician:.....

Medical license Number:.....

Estimated expenses:.....

The patient /Customer (s) and their entourage (s) have to quarantine in any health establishment not less than 14 day.

Payment for this wellness program is to be paid by:

The patient/customer

Health Insurance/Life Insurance

The Government of.....

(Name of the Payer Agency.....)

Other Health Plan.....

(Signature).....(Authorized Representative)

Name and Capacity.....

Date (...../...../.....)

(Health Establishment Seal)

International Health Division No.0712.06/...../Year...20..... Date..... Time..... (Signature)..... (Authorized of International Health Division, Department of Health Service Support)
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Note: The patient/customer (s) who request for treatment in the Wellness Quarantine program must pay all actual expense for themselves and their entourage (s) unless the patient/customer (s) is unable to pay for any reasons, the health establishment (s) where the patient/customer and entourage (s) receive the treatment, shall accept to have a responsibility for all expense occurred without a claim form the government agencies



Affidavit of Support

This is to certify that individuals listed below are accompanying me during my visit for treatment of the Wellness Quarantine program in Thailand. These individuals of not exceed 3 persons in total are my assistants during the course of treatment. They will have to quarantine in any health establishment not less than 14 day. And I will take full financial responsibility to their provisions and accommodations.

(Patient/Customer's details) Title: Mr: Ms: Mrs: others.....

Name:Passport: NO.

Nationality:.....Departure Country:

1. List of entourages:

First Name/Last Name.....

Sex: Male Female Date of Birth/...../.....(dd/mm/yyyy)

Passport: NO.

Nationality:.....Departure Country:

Relationship.....

2. List of entourages:

First Name/Last Name.....

Sex: Male Female Date of Birth/...../.....(dd/mm/yyyy)

Passport: NO.

Nationality:.....Departure Country:

Relationship.....

3. List of entourages:

First Name/Last Name.....

Sex: Male Female Date of Birth/...../.....(dd/mm/yyyy)

Passport: NO.

Nationality:.....Departure Country:

Relationship.....

I and my entourages will arrive on (dd/mm/yyyy).....

By Land Checkpoint.....name.....

Airline.....name.....Flight No.at.....

I hereby certify that the persons listed above are under my financial responsibility during my visit for treatment in Thailand

Signature.....Date.....(dd)...../(mm)...../(yyyy).....

The form needed to be completed and submitted to elective health establishment before you arrive. Please bring originals to process the immigration at custom control, Airport, Thailand

(Health Establishment Seal)