**Notification and Consent for Collecting, Processing and Using of Personal Information**

**Notification**

To collect, process, and use the personal information that you provided for confirming your identity or will be provided by you in the future based on various reasons (hereinafter referred to as the personal information), we would like to inform you of the followings：

1. Purpose of collection：To confirm your identity and to control/prevent pandemic for the public health.
2. Types of personal information：Name, phone numbers, health condition, and travel history.
3. Place of use：Taiwan (Republic of China)
4. User：Industrial Technology Research Institute and the governmental authority of public health.
5. Method of use：Without violating the purpose of collection, the personal information will be used via the Internet, email, writing, fax and other legal methods. Further, for the necessity of controlling Covid-19, the personal information may be provided to the governmental authority of public health to conduct the pandemic investigation and/or contact individual according to the Communicable Disease Control Act.
6. You can claim in writing the following rights：
7. Inquire or request viewing
8. Request for a copy
9. Request for supplement or correction
10. Request to stop collecting, processing or using
11. Request for deletion
12. We will keep your personal information confidential and protected in accordance with relevant government regulations.

**Industrial Technology Research Institute**

**Consent**

I have read and understood the above notification, and agree to let the Industrial Technology Research Institute to collect, process and use my personal information within the scope of the above notification.

**Signature：** Date:

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| **COVID-19 Health Declaration** | | | |
| **Name** | **Gender**   * Male * Female | | **Telephone in Taiwan** |
| **Company** |
| 1. **Have you been entered Taiwan within 7 days? 🞎 Yes，Date of entry: 🞎 No** 2. **Have you been identified as a home care of COVID-19 confirmed cases within 14 days?**   🞎 **Yes** 🞎 **No**   1. **Have you been identified as a contact of COVID-19 confirmed cases within 7 days?**   **🞎 Yes，Date of last contact: 🞎 No**   1. **During the past 7 days, have you had any of following symptoms?**   **🞎 Fever 🞎 Cough 🞎 Sore throat 🞎 Runny nose 🞎 Shortness of breath**  **🞎 Weak limbs (tiredness) 🞎 Loss of taste 🞎 Loss of smell 🞎 Diarrhea**  **🞎 No**   1. **Your COVID-19 vaccinated situation：**🞎 **One dose** 🞎 **Two doses** 🞎 **Three doses or above**   🞎 **Not yet** | | | |
| **Signature** | | **Date（YYYY/MM/DD）** | |