RETURNING RESIDENT APPLICATION FOR EXEMPTION OF QUARANTINE FEES

1. **Last Name:** ______________________________ **2. First Name:** ___________________________________

3. **Date of Birth:** _____/_____/_____ **4. Residential Address**: _________________________________
DD/MM/YYYY

4. **Telephone Number:** ___________________ **5. Email Address**: _______________________________

6. **Please select applicable category:** a. Returning Student ☐ b. Health care ☐ c. Forceful Repatriation ☐
d. Death of immediate Family Member ☐ (mother, father, sister, brother, son, daughter, grandparents)

7. Proposed Date for internment of Family Member _____/_____/_____
Residents returning home to facilitate the internment of a family member must schedule such services to accommodate the 14-day quarantine period.

8. **Intended Date of travel Into Saint Lucia:** _____/_____/_____ **9. Flight Number:** __________________
DD/MM/YYYY

10. **Reference Number of your Travel Registration Form:** ______________

11. **Are your Employed:** Yes ☐ No ☐ If yes, please state name and Address of Employer.
____

Should the government agree to fund part of your expenses, how much of it can you fund? _________________

12. **Please specify Reason for State Funded Assistance.**
____

13. If you are approved for State Quarantine cost exemption, are you able to quarantine at home following the receipt of a Negative COVID-19 result at State Quarantine? Yes ☐ No ☐

14. All applications will require supporting documents prior to approval. Please attach as applicable.
    - Proof of Medical care ☐
    - Death Certificate ☐
    - Letter of termination of employment ☐ (valid for three months only)
    - Proof of completion of studies ☐

I ______________________________ hereby agree to the Government of Saint Lucia's quarantine policy and acknowledge that a full 14-day period is observed.

I acknowledge that I must wear an Amber Solution watch and a BioIntelliSense sticker at a cost of EC$260.00 These electronic devices will be rented for the period and will be mapped to my residential perimeters and will also monitor vital signs. I acknowledge that any breach of protocol can result in stringent penalties including charges preferred against me.

Signature: ______________________ **Date:** _____/_____/_____

FOR USE BY MINISTRY OF HEALTH AND WELLNESS

Approved: ___________ **Denied:**_____________ **Date:** _____/_____/_____

Reason for Denial: ____

Please email all applications and supporting documents to: cmohealth@gosl.gov.lc A 7 day period is necessary for processing of applications.