

# 关于菲律宾皇家航空马尼拉中国航线核酸检测的最新通知

更新日期：2021年7月24日

更新内容：马尼拉始发旅客需多做一次核酸检测，该新增检测由航司免费提供；更改了第二次检测（核酸+抗体检测）的地点和时间，检测相关信息详见下文！  
没有疫苗证明但是检测结果仅有IGG为阳性的旅客，可以选择购买14天后的同一个航班（详见温馨提示第2点）！

● **第一次检测：核酸检测+抗体检测**（旅客自费，共计1750人民币/人）：

【检测机构】St. Luke’s Medical Center Global City [MAIN ENTRANCE -正门]

【地址】Rizal Drive corner 32nd Street. and 5th Avenue Taguig

(<https://goo.gl/maps/MxUunPF6bQxuYFzf8>)

● **第二次检测：核酸检测+抗体检测**（航司免费提供）

【检测机构】心地医疗检测中心 Heartland medical and diagnostic center

【地址】B5 L2 Diosdado Macapagal Blvd, cor Coral Way East, Pasay

(<https://goo.gl/maps/gvLlerapRWMAGbRv5>)

【马尼拉联系人】Love1y

【联系电话】：09175477843

## 重要提示★检测时间

✧ **不是在航司指定团队监督下的检测视为无效；未能按通知预约时间到达检测的视为放弃！**

航班	第一次核酸+抗体检测		第二次核酸+抗体检测		航班日期
	检测日期	检测时间	检测日期	检测时间	
RW368 马尼拉-无锡 09:30-13:00	7月26（周1）	0600-1200	7月27（周2）	0600-0900	2021/7/28
	8月02（周1）	0600-1200	8月03（周2）	0600-0900	2021/8/4
	8月09（周1）	0600-1200	8月10（周2）	0600-0900	2021/8/11
	8月16（周1）	0600-1200	8月17（周2）	0600-0900	2021/8/18
	8月23（周1）	0600-1200	8月24（周2）	0600-0900	2021/8/25
	8月30（周1）	0600-1200	8月31（周2）	0600-0900	2021/9/1
	9月06（周1）	0600-1200	9月07（周2）	0600-0900	2021/9/8
	9月13（周1）	0600-1200	9月14（周2）	0600-0900	2021/9/15
	9月20（周1）	0600-1200	9月21（周2）	0600-0900	2021/9/22
	9月27（周1）	0600-1200	9月28（周2）	0600-0900	2021/9/29
	10月04（周1）	0600-1200	10月05（周2）	0600-0900	2021/10/6
	10月11（周1）	0600-1200	10月12（周2）	0600-0900	2021/10/13
	10月18（周1）	0600-1200	10月19（周2）	0600-0900	2021/10/20
	10月25（周1）	0600-1200	10月26（周2）	0600-0900	2021/10/27

### 温馨提示：

- 1、 做检测按照上表日期/时间，不用预约。四次检测的结果为阴性（两次核酸阴性；两次抗体检测要求IGM和IGG都为阴性）的旅客，可正常值机；检测结果为阳性的旅客，将被拒绝乘机；若旅客有疫苗证并且按照要求提早报备而且通过核实的，则IGG阳性旅客可正常值机，核酸阳性或IGM阳性旅客将被拒绝登机。
- 2、 接大使馆通知，若旅客没有疫苗证明，且检测结果为检测核酸阴性+IGM阴性+IGG阳性的话，则可选择买14天后的同一个航班。如果检测结果还是核酸阴性+IGM阴性+IGG阳性的话，就上传2次的检测报告，使馆会审核发放绿码。

- 3、 检测当天请带笔、护照原件和**四份护照复印件**（两份用于第一次检测，两份用于第二次检测）；如果旅客的护照正在移民局办理申请，必须携带移民局相关证明（必须有移民局签字和LOGO）；如果旅客没有护照，必须有证明护照是已报失。不符合以上条件的旅客将不被允许参加检测，旅客所购机票视为放弃。
- 4、 **核酸检测当天请在工作人员指导下加入微信群**，以便旅客收取检测报告扫描件后申请HS码。乘机的旅客请在航班起飞当日在机场柜台处领取检测报告原件。如有问题，请务必于检测当日与现场工作人员沟通。
- 5、 **进行核酸检测和第一次抗体检测**时，检测医院的儿科医生上班时间为早上10：30。出于安全考虑，**请有陪同婴儿和9岁（含）以下儿童的客人尽量在检测当天早上10：30到达医院进行检测。**
- 6、 在医院填表（请正确填写名字和护照号码，避免检测报告出来后有误）。
- 7、 第一次核酸检测和第一次抗体检测共计**1750人民币/人**（第一次抗体检测增加IGG检测，检测费用上调至1750人民币/人），第二次检测（核酸+抗体检测）由航司免费提供。
- 8、 检测费请务必提前一天支付，检测费1750人民币/人请汇入以下账户：  
【注意：汇款时必须备注乘机人姓名和航班号，方便核对；**如果没有备注名字或汇错账户，旅客须现场重新付款参加检测**；检测当天请把汇款截图给现场航司工作人员查看，以做证明，感谢配合。】

银行账号：6227 0012 1688 0039 098	银行账号：6225220104243092
开户银行：建设银行上海江苏路支行	开户银行：上海浦东发展银行股份有限公司水务大厦支行
收款人：李惠梅	收款人：李惠梅

- 9、 **所有搭乘航班的旅客必须提前自行注册机场码**，进入机场时会有机场工作人员对其进行检查。机场码注册的**详细流程见第11页**。
- 10、 所有搭乘飞机的旅客必须穿戴防护服、面罩和口罩；没有按要求穿戴的旅客将被拒绝值机！
- 11、 根据菲律宾跨机构防疫组IATF的最新要求，自6月10日起，所有在菲律宾的外国公民在医院进行新冠病毒核酸和血清抗体检测时，必须交给医院**两张护照首页复印件和在菲律宾的详细地址居留证明（两次核酸+抗体检测，旅客需要准备4份护照首页复印件和4份居留证明）**。如不提供上述资料，医院有权拒绝为乘客进行检测。以下是政府及医院要求旅客提供的**居留证明类别**：
- （1）ARC（Alien Registration Card）
  - （2）账单（必须有旅客的姓名和地址）
  - （3）医疗证明书（必须有旅客的姓名和地址）
  - （4）LT0驾照
  - （5）居住许可证（适用于公寓住户）
  - （6）Barangay Clearance（菲律宾政府签发的一种居留证）
  - （7）酒店住宿证明（必须是原件）
  - （8）政府签发的身份证
  - （9）租赁合同
  - （10）公司ID（必须有本地地址）
  - （11）租赁证书
  - （12）酒店/公寓的收据（必须有旅客的姓名和地址）
  - （13）公寓ID（必须有旅客的姓名）
  - （14）入住表格（必须有旅客的姓名和大楼管理员的签名）
- 注：搬家证明不可作为居留证明！ID或证明上面的地址必须与旅客在CIF上的地址一致！
- 12、 关于疫苗证的报备：**旅客购票后须马上发邮件报备疫苗证，并在做第一次检测的时候拿出疫苗证给工作人员再次核实**。如果因为旅客不及时发邮件报备疫苗证导致不够时间核实疫苗证的真实有效性，旅客自己承担相关责任。报备邮件具体要求如下：
- 【报备邮箱】[Lovely.lvolidays@gmail.com](mailto:Lovely.lvolidays@gmail.com)
- 【邮件名称】**疫苗报备+航班日期+名字（拼音）**
- 【邮件内容】**需附上疫苗证明，护照，旅客手机号码**

第一次检测的流程：

# 血清和核酸检测流程

正门入口处， 在保安那边拿第一张表（健康申明），  
填完给保安查看。

\* 如果大堂里有很多人，请在外面排队，  
大堂里的人少一些保安会让你进去的时候.\*



正门进去后， 右手边再拿第 2 张表格，填写清楚后交给负责人。

\* 检查付款证明 （截图必须有旅客名字）\*



请稍安勿躁，等候叫名字面试。  
面试后， 请等候叫名字进行检测：

- 1. 先做血清
- 2. 做完血清，必须去排队拍照
- 3. 拍完，与大使馆报名 \*写清楚中文名字\*
- 4. 报名完， 做核酸检测



做完核酸检测，可以回家了！  
（航班起飞当天会有人把报告原件送去机场给你们, 在值机柜台领取）

中文名必须【正楷字体】，  
一笔一划写自己的名字，


序号 #	姓 (拼音)	名 (拼音)	中文名	性别	出生日期	护照号	签名
1			签名 (不要潦草字体)				签名 (不要潦草字体)

签名 2 次

名字看不清楚， 无法审批健康（HS）绿码



移民局相关证明样版:



REPUBLIC OF THE PHILIPPINES  
DEPARTMENT OF JUSTICE  
**BUREAU OF IMMIGRATION**  
MAGALLANES DRIVE, INTRAMUROS  
1002 MANILA

In Re:

XXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXX

-Applicant-

X-----X

ORDER

On 04 November 2020, applicant filed a request for updating of stay and permission to leave. Records disclose:

Arrival date:07 December 2019No. of months requested:11

Admission:9a-30 days (VUA)Months overstayed:10

Latest authorized stay:06 January 2020Application filed by:Applicant

a. Applicant bears no derogatory record as of 04 November 2020 based on the attached Certification issued by Catalino Z. Alfonso;

b. Applicant has **Thirty Day (30) Temporary Visitor's Visa Upon Arrival (TV-VUA)** with 

XXXXXXXXXXXXXXXXXXXX

 as his travel operator;

c. Applicant provides confirmed ticket to Wuxi via RW368 dated 18 November 2020; and

d. Applicant failed to leave the country based on itinerary indicated without valid justification, in violation of the terms and conditions pursuant to his/her VUA order.

We note that the **Department of Justice Circular No. 001, Section 3(b)**, dated **08 January 2020**, expressly provides that "No Extension or Renewal of a TV-VUA shall be allowed".

WHEREFORE, premises considered, Applicant is hereby **ORDERED**:

1. To pay updating fees, fines, and penalties;

2. To secure Emigration Clearance Certificate (ECC) and NBI Clearance;

3. To leave on **18 November 2020**; and

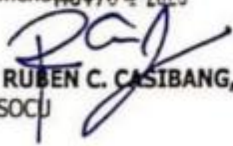
4. To be barred from entering the country pursuant to Department of Justice Circular No. 001.

The Tourist Visa Section shall implement this Order.

SO ORDERED.


Recommended by: 

NOV 04 2020



ATTY. RUBEN C. CASIBANG, JR.  
Head, SOCU

APPROVED / ~~DISAPPROVED~~



JAIME H. MORENTE  
Commissioner

PATRIOTISM • INTEGRITY • PROFESSIONALISM



REPUBLIC OF THE PHILIPPINES  
DEPARTMENT OF JUSTICE  
**BUREAU OF IMMIGRATION**  
MAGALLANES DRIVE, INTRAMUROS  
1002 MANILA

In re:

Travel Doc. N  
CHN  
Female

**ORDER**

On 30 October 2020, Tourist Visa Section (TVS) endorsed to the Immigration Regulation Division. [redacted] date application for Temporary Visitor Visa.

Records show: (i) On 22 January 2020, NAIA-based immigration authorities admitted [redacted] valid stay ended on 29 January 2020; and (iii) [redacted] overstayed for 10 months in the country.

To address the foregoing, we order [redacted] to:

1. Pay immigration fees, fines and penalties to be computed from by Tourist Visa Section (TVS);
2. Pay IARC amounting **Php15,000.00** and Express Lane Fee amounting to **Php10,000.00**;
3. Secure Emigration Clearance Certificate; and
4. **LEAVE** the Philippines via NAIA within thirty (30) days from receipt of this Order.

TVS and ARD shall insure the implementation of this Order.

Give copies of this Order to [redacted].

**IT IS SO ORDERED.**

Prepared by:

**RAUL A. MEDINA**  
Acting Chief, Tourist Visa Section  
Date signed: NOV 30 2020

Recommending Approval:

**ROGELIO D. GEVERO JR**  
Chief, Immigration Regulation Division  
Date signed: 03 NOV 2020

**APPROVED/DISAPPROVED**

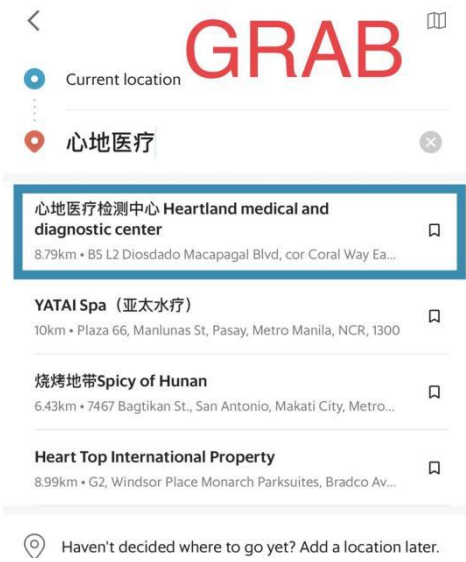
**JAIME H. MORENTE**  
Commissioner  
Date signed: 03 2021

第一次检测（核酸+抗体检测）地址：



必须在医院大门口进去开始检测操作。  
不允许自己去急诊室做核酸测，  
必须按照我们给出的预约方式做，如有自己跑去急诊室做的不予登机！

第二次检测（核酸+抗体检测）地址：



去医院检测必须戴口罩和面罩（两种都要戴）！

下图为面罩（参考）：



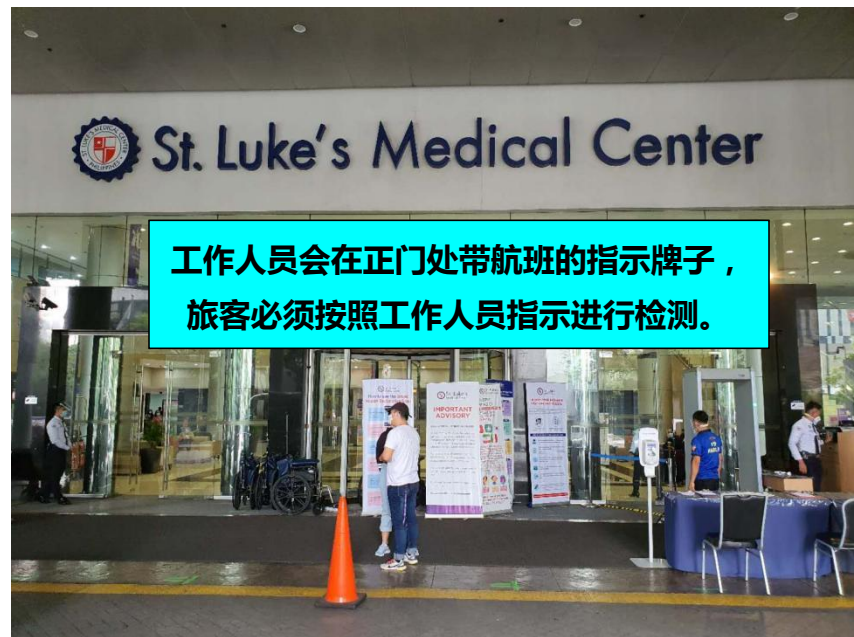
下图为口罩：



去医院检测不可以戴以下类型的口罩







工作人员会在正门处带航班的指示牌子，  
旅客必须按照工作人员指示进行检测。



正门入口处，在保安那边拿第一  
张表（健康申明），  
填完给保安查看。

**HEALTH DECLARATION 健康声明**

Due to the recent worldwide outbreak of COVID-19, St. Luke's Medical Center would like to ensure that our patients/customers and employees are safe from exposure to the disease. In line with this, we are requesting all patients, including companions and visitors, to complete this form. 因近期全球爆发新型冠状病毒，本院为确保患者/客户及员工的安全，要求所有患者及同伴和访客认真填写以下表格。

The data that you provide is strictly confidential and used for hospital reference only. 您提供的信息仅供医院使用，本院会严格保密。

Name: **ZHANG, SAN** Age: **28** Sex: **M** Contact #: **09179930111**  
I am a ( ) Patient ( ) Visitor ( ) Companion ( ) Others: **SWAB**  
我是 ( ) 患者 ( ) 访客 ( ) 同伴 ( ) 其他: **是 否**

Please tick an answer for every question item 以下问题请回答是或否: **YES NO**

Have you been recently tested for COVID-19? 近期是否做过核酸检测? **YES NO**  
Date swabbed: 如有，请写日期: Result (if available): 检测结果 (如有):  
Have you been evaluated as Probable or Suspected for COVID-19? 是否被诊断为疑似病例?  
If YES, when did your quarantine start? 如是，隔离期开始日期是: **YES NO**  
Do you have any travel history in the past 14 days? 近14天是否有旅行记录?  
If YES, when and where? 如有，请提供外出日期和到站地点: **YES NO**  
Did you come in close contact or staying in the same close environment with someone who is a confirmed COVID-19 case? 是否与确诊患者有密切接触或住在同一密闭环境中?  
Did you come in close contact with a Probable or Suspected person with COVID-19? 是否与疑似病例有过密切接触?  
Have you experienced the following symptoms recently? 您近期是否有以下症状:  
Fever (>38°C) 发烧 (高于38度) **YES NO**  
Diarrhea, Nausea, or Vomiting 腹泻、恶心或呕吐 **YES NO**  
Shortness of breath or other respiratory symptoms 呼吸急促或其他呼吸道症状 **YES NO**  
Other respiratory symptoms: 具体症状: **YES NO**  
Headache 头痛 **YES NO**  
Joint Pain or Muscle Pain 关节痛或肌肉痛 **YES NO**  
Flu-like symptoms such as: 类似流感的症状，例如:  
Chills or repeated shaking with chills 畏寒或反复打寒战 **YES NO**  
Body aches 浑身酸痛 **YES NO**  
Sore throat 咽喉痛 **YES NO**  
Runny Nose or Sneezing 流鼻涕或打喷嚏 **YES NO**  
Cough and colds 咳嗽和感冒 **YES NO**  
New loss of smell and/or taste 近期丧失嗅觉和味觉 **YES NO**  
Eye discharge 眼睛出现分泌物 **YES NO**  
Skin rash or discoloration of toes/fingers 皮疹或手脚趾变色 **YES NO**  
Loss of speech or movement 丧失语言和行动功能 **YES NO**

I agree that the information provided in this document is true and correct to the best of my knowledge and understand that any dishonest answers may have serious legal and public health implications under RA 11332. 我保证以上申报内容正确属实，如有隐瞒或虚报填报，将会被依法追究相关法律责任。

我保证以上申报内容正确属实。  
I declare that all information disclosed above is TRUE and CORRECT.  
签字: **ZHANG, SAN** 日期/时间: **07/19/2020**  
批准人: 姓名: 日期/时间: 姓名: 日期/时间:  
(Name & signature of associate) (Name & signature of associate)

SLMC-IPC-5-56 REV01 (May 14, 2020)

正门进去后，右手边再拿第2张表格，填写清楚  
后交给负责人。请稍安勿躁，等候叫名字面试。

**Case Investigation Form Coronavirus (COVID-19) Version 9**

1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. This is not a self-administered questionnaire.  
2) Please be advised that (CIFs) are only allowed to obtain 1 copy of accomplished CIF from a patient.  
3) Please fill out all blanks and put a check mark, or the appropriate box. Never leave an item blank (write N/A). Items with \* are required fields. All dates must be in MM/DD/YYYY format.

**Part 1. Patient Information**

1.1. Patient Profile  
Last Name\* 姓: First Name (and Suffix)\* 名字: Middle Name\* N/A  
Birthdate (MM/DD/YYYY)\* 出生日期 (MM/DD/YYYY): Age\* 年龄: Sex\* 性别: ☐ Male 男 ☐ Female 女  
Civil Status\* 婚姻状况: ☐ Single 单身 ☐ Married 已婚 ☐ Divorced 离婚 ☐ Widowed 寡妇  
Occupation 职业: Works in a closed setting? ☐ Yes ☐ No ☐ Unknown  
1.2. Current Address in the Philippines and Contact Information\* (Provide address of institution if patient lives in closed settings, see 2.5) 菲律宾目前地址  
House No./Lot/Bldg./T 门牌号/地名: Street/Park/Slip 街名: Barangay: Municipality/City\* 城市  
Province\* 省: Home Phone No. (& Area Code) 家电话号: Cellphone No.\* 手机号码: Email Address 电子邮箱  
1.3. Permanent Address and Contact Information\* (if different from current address) 永久地址，如跟上面不一样  
House No./Lot/Bldg./T 门牌号/地名: Street/Park/Slip 街名: Barangay: Municipality/City  
Province: Home Phone No. (& Area Code) Cellphone No. Email Address  
1.4. Current Workplace Address and Contact Information\* 工作地址  
Lot/Bldg./T 门牌号/地名: Street 街名: Barangay: Municipality/City 城市  
Province: 省: Name of Workplace 工作场所名称: Phone No./Cellphone No. 手机号码: Email Address 电子邮箱  
1.5. Special Population (Indicate further details on exposure and travel history in Part 3)  
Health Care Worker\* ☐ Yes, name of health facility: and location: ☐ No  
Returning Overseas Filipino\* ☐ Yes, country of origin: and Passport number: ☐ No  
Foreign National Traveler\* ☐ Yes, country of origin: China ☐ Other: ☐ No  
Locally Stranded Individual / APOR / Local Traveler\* ☐ Yes, City, Municipality, & Province of origin: ☐ No  
Lives in Closed Settings\* ☐ Yes, institution type: and name: ☐ No  
(e.g., prisons, residential facilities, retirement communities, care homes, camps, etc.)

**Part 2. Case Investigation Details**

2.1. Consultation Information  
Have previous COVID-19 related consultation? ☐ Yes, Date of First Consult (MM/DD/YYYY): ☐ No  
Name of facility where first consult was done: ☐ Yes ☐ No  
2.2. Disposition at Time of Report\* (Provide name of hospital/isolation/quarantine facility)  
☐ Admitted in hospital: Date and time admitted in hospital: ☐ No  
☐ Admitted in isolation/quarantine facility: Date and time isolated/quarantined in facility: ☐ No  
☐ In home isolation/quarantine: Date and time isolated/quarantined at home: ☐ No  
☐ Discharged to home: If discharged: Date of Discharge (MM/DD/YYYY): ☐ No  
2.3. Health Status at Consult\* (Refer to Appendix J)  
☐ Asymptomatic ☐ Mild ☐ Moderate ☐ Severe ☐ Critical  
2.4. Case Classification\* (Refer to Appendix J)  
☐ Suspect ☐ Probable ☐ Confirmed ☐ Non-COVID-19 Case  
2.5. Vaccination Information\* (Refer to Appendix J)  
Date of vaccination\*: Name of Vaccine\*: Dose number (e.g., 1st, 2nd): Vaccination center/facility: Region of health facility: Adverse event/s? ☐ Yes ☐ No  
☐ Yes ☐ No

面试后，请等候叫名字进行核酸检测。  
做完检测，就可以自行离开！





# Case Investigation Form Coronavirus Disease (COVID-19)

Version 9



- 1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. **This is not a self-administered questionnaire.**
- 2) Please be advised that DRUs are only allowed to obtain **1 copy of accomplished CIF** from a patient.
- 3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank (write N/A). **Items with \* are required fields.** All dates must be in **MM/DD/YYYY** format.

Disease Reporting Unit*		DRU Region and Province		PhilHealth No.*	
Name of Interviewer		Contact Number of Interviewer		Date of Interview (MM/DD/YYYY)*	
Name of Informant (if applicable)		Relationship		Contact Number of Informant	
If existing case (check all that apply)*	<input type="checkbox"/> Not applicable (New case)	<input type="checkbox"/> Update case classification	<input type="checkbox"/> Update disposition		
	<input type="checkbox"/> Not applicable (Unknown)	<input type="checkbox"/> Update vaccination	<input type="checkbox"/> Update exposure / travel history		
	<input type="checkbox"/> Update symptoms	<input type="checkbox"/> Update lab result	<input type="checkbox"/> Others, specify: _____		
	<input type="checkbox"/> Update health status / outcome	<input type="checkbox"/> Update chest imaging findings			
Type of Client*	<input type="checkbox"/> COVID-19 Case (Suspect, Probable, or Confirmed) <input type="checkbox"/> Close Contact <input type="checkbox"/> For RT-PCR Testing (Not a Case of Close Contact)				
Testing Category/Subgroup* (Check all that apply, refer to Appendix 2)		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J			

<b>Part 1. Patient Information</b>			
<b>1.1. Patient Profile</b>			
Last Name* 姓	First Name (and Suffix)* 名字	Middle Name* N/A	
Birthday (MM/DD/YYYY)* 出生日期 (月/日/年)	Age* 年龄	Sex* 性别 <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	
Civil Status 婚姻情况	Nationality* 国籍		
Occupation 职业	Works in a closed setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		
<b>1.2. Current Address in the Philippines and Contact Information* (Provide address of institution if patient lives in closed settings, see 1.5) 菲律宾目前地址</b>			
House No./Lot/Bldg.* 门牌号/楼名	Street/Purok/Sitio* 街名	Barangay*	Municipality/City* 城市
Province* 省	Home Phone No. (& Area Code) 家电话号码	Cellphone No.* 手机号码	Email Address 电子邮箱
<b>1.3. Permanent Address and Contact Information (if different from current address) 永久地址, 如果跟上面不一样</b>			
House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address
<b>1.4. Current Workplace Address and Contact Information 工作地址</b>			
Lot/Bldg. 门牌号/楼名	Street 街名	Barangay	Municipality/City 城市
Province 省	Name of Workplace 工作场所名称	Phone No./Cellphone No. 手机号码	Email Address 电子邮箱
<b>1.5. Special Population (indicate further details on exposure and travel history in Part 3)</b>			
Health Care Worker*	<input type="checkbox"/> Yes, name of health facility: _____ and location: _____ <input checked="" type="checkbox"/> No		
Returning Overseas Filipino*	<input type="checkbox"/> Yes, country of origin: _____ and Passport number: _____ <input checked="" type="checkbox"/> No OFW: <input type="checkbox"/> OFW <input type="checkbox"/> Non-OFW		
Foreign National Traveler*	<input checked="" type="checkbox"/> Yes, country of origin: <u>China</u> and Passport number: <u>护照号码</u> <input type="checkbox"/> No		
Locally Stranded Individual / APOR / Local Traveler*	<input type="checkbox"/> Yes, City, Municipality, & Province of origin _____ <input checked="" type="checkbox"/> No <input type="checkbox"/> Locally Stranded Individual <input type="checkbox"/> Authorized Person Outside Residence / Local Traveler		
Lives in Closed Settings*	<input type="checkbox"/> Yes, institution type: _____ and name: _____ <input checked="" type="checkbox"/> No (e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)		

<b>Part 2. Case Investigation Details</b>					
<b>2.1. Consultation Information</b>					
Have previous COVID-19 related consultation?		<input type="checkbox"/> Yes, Date of First Consult (MM/DD/YYYY)* _____ <input checked="" type="checkbox"/> No			
Name of facility where first consult was done					
<b>2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)</b>					
<input type="checkbox"/> Admitted in hospital		Date and Time admitted in hospital _____			
<input type="checkbox"/> Admitted in isolation/quarantine facility		Date and Time isolated/quarantined in facility _____			
<input type="checkbox"/> In home isolation/quarantine		Date and Time isolated/quarantined at home _____			
<input type="checkbox"/> Discharged to home		If discharged: Date of Discharge (MM/DD/YYYY)* _____ <input type="checkbox"/> Others: _____			
<b>2.3. Health Status at Consult* (Refer to Appendix 3)</b>		<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical			
<b>2.4. Case Classification* (Refer to Appendix 1)</b>		<input type="checkbox"/> Suspect <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Non-COVID-19 Case			
<b>2.5. Vaccination information* 疫苗接种信息</b>					
Date of vaccination* 接种日期	Name of Vaccine* 疫苗名称	Dose number (e.g. 1 <sup>st</sup> , 2 <sup>nd</sup> )* 剂量数	Vaccination center/facility 疫苗接种中心	Region of health facility 卫生设施区域	Adverse event/s? 不良事件
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No



2.6. Clinical Information														
Date of Onset of Illness (MM/DD/YYYY)* _____					Comorbidities (Check all that apply if present)									
Signs and Symptoms (Check all that apply)														
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Fever _____ °C <input type="checkbox"/> Cough <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Sore throat <input type="checkbox"/> Coryza					<input type="checkbox"/> Dyspnea <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Anosmia (loss of smell, w/o any identified cause) <input type="checkbox"/> Ageusia (loss of taste, w/o any identified cause) <input type="checkbox"/> Others, specify _____					<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Others _____				
					Pregnant?		<input type="checkbox"/> Yes, LMP (MM/DD/YYYY) _____			<input type="checkbox"/> No				
					High-risk pregnancy?		<input type="checkbox"/> Yes			<input type="checkbox"/> No				
					Was diagnosed to have Severe Acute Respiratory Illness?					<input type="checkbox"/> Yes <input type="checkbox"/> No				
Chest imaging findings suggestive of COVID-19														
Date done		Chest imaging done		Results										
		<input type="checkbox"/> Chest radiography <input type="checkbox"/> Chest CT <input type="checkbox"/> Lung ultrasound <input type="checkbox"/> None		<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist. <input type="checkbox"/> Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist. <input type="checkbox"/> Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms <input type="checkbox"/> Other findings, specify _____										
2.7. Laboratory Information														
Have tested positive using RT-PCR before? *		<input type="checkbox"/> Yes, date of specimen Collection (MM/DD/YYYY)* _____ <input type="checkbox"/> No Laboratory* _____ No. of previous RT-PCR swabs done _____												
Date collected*		Date released		Laboratory*		Type of test*				Results*				
						<input type="checkbox"/> RT-PCR (OPS) <input type="checkbox"/> Antigen; reason _____ <input type="checkbox"/> RT-PCR (NPS) <input type="checkbox"/> brand of kit _____ <input type="checkbox"/> RT-PCR (OPS and NPS) <input type="checkbox"/> Antibody Test <input type="checkbox"/> Others: _____				<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____				
						<input type="checkbox"/> RT-PCR (OPS) <input type="checkbox"/> Antigen; reason _____ <input type="checkbox"/> RT-PCR (NPS) <input type="checkbox"/> brand of kit _____ <input type="checkbox"/> RT-PCR (OPS and NPS) <input type="checkbox"/> Antibody Test <input type="checkbox"/> Others: _____				<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____				
2.8. Outcome/Condition at Time of Report*														
<input type="checkbox"/> Active (currently admitted/isolation/quarantine) <input type="checkbox"/> Recovered, date of recovery (MM/DD/YYYY)* _____ <input type="checkbox"/> Died, date of death (MM/DD/YYYY)* _____														
If died, cause of death*		Immediate Cause:				Antecedent Cause:								
		Underlying Cause:				Contributory Conditions:								
PART 3. Contact Tracing: Exposure and Travel History														
History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? *						<input type="checkbox"/> Yes, date of last contact (MM/DD/YYYY)* _____ <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
Has the patient been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? *						<input type="checkbox"/> Yes, International <input type="checkbox"/> Yes, Local <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown exposure								
If International Travel, country of origin				Inclusive travel dates:				From:		To:				
				With ongoing COVID-19 community transmission?				<input type="checkbox"/> Yes		<input type="checkbox"/> No				
Airline/Sea vessel		Flight/Vessel Number		Date of departure (MM/DD/YYYY)				Date of arrival in PH (MM/DD/YYYY)						
If Local Travel, specify travel places (Check all that apply, provide name of facility, address, and inclusive travel dates in MM/DD/YYYY)														
Place Visited		Name of Place		Address (Region, Province, Municipality/City)		Inclusive Travel Dates From: To:		With ongoing COVID-19 Community Transmission?						
<input type="checkbox"/> Health Facility								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Closed Settings								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> School								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Workplace								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Market								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Social Gathering								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Others								<input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Transport Service, specify the following:														
Airline / Sea vessel / Bus line / Train		Flight / Vessel / Bus No.		Place of Origin		Departure Date (MM/DD/YYYY)		Destination		Date of Arrival (MM/DD/YYYY)				
- If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date - If asymptomatic, provide names and contact numbers of persons who were with the patient on the day specimen was submitted for testing until this date						Name (Use the back page if needed)			Contact Number					

## Appendix 1. COVID-19 Case Definitions

SUSPECT	PROBABLE
<p>A) A person who meets the <b>clinical AND epidemiological criteria</b></p> <ul style="list-style-type: none"> <li><b>Clinical criteria:</b> <ol style="list-style-type: none"> <li>1) Acute onset of fever AND cough <b>OR</b></li> <li>2) Acute onset of <b>ANY THREE OR MORE</b> of the following signs or symptoms; fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia / nausea/ vomiting, diarrhea, altered mental status. <b>AND</b></li> </ol> </li> <li><b>Epidemiological criteria</b> <ol style="list-style-type: none"> <li>1) Residing/working in an area with high risk of transmission of the virus (e.g closed residential settings and humanitarian settings, such as camp and camp-like setting for displaced persons), any time w/in the 14 days prior to symptoms onset <b>OR</b></li> <li>2) Residing in or travel to an area with community transmission anytime w/in the 14 days prior to symptoms onset; <b>OR</b></li> <li>3) Working in health setting, including w/in the health facilities and w/in households, anytime w/in the 14 days prior to symptom onset; <b>OR</b></li> </ol> </li> </ul> <p>B) A patient with <b>severe acute respiratory illness</b> (SARI: acute respiratory infection with history of fever or measured fever of <math>\geq 38^{\circ}\text{C}</math>; cough with onset w/in the last 10 days; and who requires hospitalization)</p>	<p>A) A <b>patient</b> who meets the <b>clinical criteria</b> (on the left) <b>AND is contact of a probable or confirmed case, or epidemiologically linked to a cluster of cases</b> which had had at least one confirmed identified within that cluster</p> <p>B) A <b>suspect case</b> (on the left) with <b>chest imaging showing findings suggestive of COVID-19 disease</b>. Typical chest imaging findings include (Manna, 2020):</p> <ul style="list-style-type: none"> <li>– Chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution</li> <li>– Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution</li> <li>– Lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms</li> </ul> <p>C) A person with <b>recent onset of anosmia (loss of smell), ageusia (loss of taste) in the absence of any other identified cause</b></p> <p>D) Death, not otherwise explained, in an <b>adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster</b> which has had at least one confirmed case identified with that cluster</p>
	CONFIRMED
	A person with <b>laboratory confirmation of COVID-19 infection</b> , irrespective of clinical signs and symptoms.


## Appendix 2. Testing Category / Subgroup

<b>A</b>	Individuals with <b>severe/critical</b> symptoms and <b>relevant history</b> of travel/contact	<b>G</b>	Residents, occupants or workers in a <b>localized area with an active COVID-19 cluster</b> , as identified and declared by the local chief executive in accordance with existing DOH Guidelines and consistent with the National Task Force Memorandum Circular No. 02 s.2020 or the Operational Guidelines on the Application of the Zoning Containment Strategy in the Localization of the National Action Plan Against COVID-19 Response. The local chief executive shall conduct the necessary testing in order to protect the broader community and critical economic activities and to avoid a declaration of a wider community quarantine.
<b>B</b>	Individuals with <b>mild</b> symptoms, <b>relevant history</b> of travel/contact, and considered <b>vulnerable</b> ; vulnerable populations include those elderly and with preexisting medical conditions that predispose them to severe presentation and complications of COVID-19	<b>H</b>	Frontliners in <b>Tourist Zones</b> :
<b>C</b>	Individuals with <b>mild</b> symptoms, and <b>relevant history</b> of travel and/or contact	<b>H1</b>	All workers and employees in the <b>hospitality and tourism sectors</b> in El Nido, Boracay, Coron, Panglao, Siargao and other tourist zones, as identified and declared by the Department of Tourism. These workers and employees may be tested once every four (4) weeks.
<b>D</b>	Individuals with <b>no symptoms</b> but with <b>relevant history</b> of travel and/or contact or high risk of exposure. These include:	<b>H2</b>	All <b>travelers</b> , whether of domestic or foreign origin, may be tested at least once, at their own expense, prior to entry into any designated tourist zone, as identified and declared by the Department of Tourism.
<b>D1</b>	- <b>Contact-traced individuals</b>	<b>I</b>	All workers and employees of <b>manufacturing companies and public service providers registered in economic zones</b> located in Special Concern Areas may be tested regularly.
<b>D2</b>	- <b>Healthcare workers</b> , who shall be prioritized for regular testing in order to ensure the stability of our healthcare system	<b>J</b>	<b>Economy Workers</b>
<b>D3</b>	- <b>Returning Overseas Filipino</b> (ROF) workers, who shall immediately be tested at port of entry	<b>J1</b>	<b>Frontline and Economic Priority Workers</b> , defined as those 1) who work in high priority sectors, both public and private, 2) have high interaction with and exposure to the public, and 3) who live or work in Special Concern Areas, may be tested every three (3) months. These include but not limited to:
<b>D4</b>	- Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin ( <b>Locally Stranded Individuals</b> ) may be tested subject to the existing protocols of the IATF		- <b>Transport and Logistics</b> : drivers of taxis, ride hailing services, buses, public transport vehicle, conductors, pilots, flight attendants, flight engineers, rail operators, mechanics, servicemen, delivery staff, water transport workers (ferries, inter-island shipping, ports)
<b>E</b>	<b>Frontliners indirectly involved in health care provision</b> in the response against COVID-19 may be tested as follows:		- <b>Food Retailers</b> : waiters, waitress, bar attendants, baristas, chefs, cooks, restaurant managers
<b>E1</b>	Those with <b>high or direct exposure to COVID-19 regardless of location</b> may be tested up to once a week. These include: <b>(1)</b> Personnel manning the Temporary Treatment and Quarantine Facilities (LGU and Nationally-managed); <b>(2)</b> Personnel serving at the COVID-19 swabbing center; <b>(3)</b> Contact tracing personnel; and <b>(4)</b> Any personnel conducting swabbing for COVID-19 testing		- <b>Education</b> : teachers at all levels of education and other school frontliners such as guidance counselors, librarians, cashiers
<b>E2</b>	Those who <b>do not have high or direct exposure to COVID-19</b> but who <b>live or work in Special Concern Areas</b> may be tested up to every two to four weeks. These include the following: <b>(1)</b> Personnel manning Quarantine Control Points, including those from Armed Forces of the Philippines, Bureau of Fire Protection; <b>(2)</b> National / Regional / Local Risk Reduction and Management Teams; <b>(3)</b> Officials from any local government / city / municipality health office (CEDSU, CESU, etc.); <b>(4)</b> Barangay Health Emergency Response Teams and barangay officials providing barangay border control and performing COVID-19-related tasks; <b>(5)</b> Personnel of Bureau of Corrections and Bureau of Jail Penology & Management; <b>(6)</b> Personnel manning the One-Stop-Shop in the Management of ROFs; <b>(7)</b> Border control or patrol officers, such as immigration officers and the Philippine Coast Guard; and <b>(8)</b> Social workers providing amelioration and relief assistance to communities and performing COVID-19-related tasks		- <b>Financial Services</b> : bank tellers
<b>F</b>	Other <b>vulnerable patients</b> and those <b>living in confined spaces</b> . These include but are not limited to: <b>(1)</b> Pregnant patients who shall be tested during the peripartum period; <b>(2)</b> Dialysis patients; <b>(3)</b> Patients who are immunocompromised, such as those who have HIV/AIDS, inherited diseases that affect the immune system; <b>(4)</b> Patients undergoing chemotherapy or radiotherapy; <b>(5)</b> Patients who will undergo elective surgical procedures with high risk for transmission; <b>(6)</b> Any person who have had organ transplants, or have had bone marrow or stem cell transplant in the past 6 months; <b>(7)</b> Any person who is about to be admitted in enclosed institutions such as jails, penitentiaries, and mental institutions.		- <b>Non-Food Retailers</b> : cashiers, stock clerks, retail salespersons
			- <b>Services</b> : hairdressers, barbers, manicurists, pedicurists, massage therapists, embalmers, morticians, undertakers, funeral directors, parking lot attendants, security guards, messengers
			- <b>Construction</b> : construction workers including carpenters, stonemasons, electricians, painters, foremen, supervisors, civil engineers, structural engineers, construction managers, crane/tower operators, elevator installers, repairmen
			- <b>Water Supply, Sewerage, Waster Management</b> : plumbers, recycling/ reclamation workers, garbage collectors, water/wastewater engineers, janitors, cleaners
			- <b>Public Sector</b> : judges, courtroom clerks, staff and security, all national and local government employees rendering frontline services in special concern areas
			- <b>Mass Media</b> : field reporters, photographers, cameramen
			All employees <b>not covered above are not required to undergo testing but are encouraged to be tested every quarter</b> . Private sector employers are highly encouraged to send their employees for regular testing at the employers' expense in order to avoid lockdowns that may do more damage to their companies.
		<b>J2</b>	

## Appendix 3. Severity of the Disease


MILD	CRITICAL
Symptomatic patients presenting with fever, cough, fatigue, anorexia, myalgias; other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhea, nausea and vomiting; loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms with <b>NO signs of pneumonia or hypoxia</b>	Patients manifesting with acute respiratory distress syndrome, sepsis and/or septic shock:
MODERATE	<b>1. Acute Respiratory Distress Syndrome (ARDS)</b>
1. Adolescent or adult with <b>clinical signs of non-severe pneumonia</b> (e.g. fever, cough, dyspnea, respiratory rate (RR) = <b>21-30 breaths/minute</b> , peripheral capillary oxygen saturation (SpO2) >92% on room air)	a. Patients with onset within 1 week of known clinical insult (pneumonia) or new or worsening respiratory symptoms, progressing infiltrates on chest X-ray or chest CT scan, with respiratory failure not fully explained by cardiac failure or fluid overload
2. Child with clinical signs of non-severe pneumonia (cough or difficulty of breathing and fast breathing [ $< 2$ months: $> 60$ ; 2-11 months: $> 50$ ; 1-5 years: $> 40$ ] and/or chest indrawing)	<b>2. Sepsis</b>
SEVERE	a. Adults with life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection. Signs of organ dysfunction include altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate or hyperbilirubinemia
1. Adolescent or adult with <b>clinical signs of severe pneumonia or severe acute respiratory infection</b> as follows: fever, cough, dyspnea, <b>RR&gt;30 breaths/minute</b> , severe respiratory distress or SpO2 $< 92\%$ on room air	b. Children with suspected or proven infection and $> 2$ age-based systemic inflammatory response syndrome criteria (abnormal temperature $> 38.5^{\circ}\text{C}$ or $< 36^{\circ}\text{C}$ ); tachycardia for age or bradycardia for age if $< 1$ year; tachypnea for age or need for mechanical ventilation; abnormal white blood cell count for age or $> 10\%$ bands), of which one must be abnormal temperature or white blood cell count.
2. Child with clinical signs of pneumonia (cough or difficulty in breathing) plus at least one of the following:	<b>3. Septic Shock</b>
a. Central cyanosis or SpO2 $< 90\%$ ; severe <b>respiratory distress</b> (e.g. fast breathing, grunting, very severe chest indrawing); general danger sign: <b>inability to breastfeed or drink, lethargy or unconsciousness</b> , or convulsions.	a. Adults with persistent hypotension despite volume resuscitation, requiring vasopressors to maintain MAP $> 65$ mmHg and serum lactate level $> 2\text{mmol/L}$
b. <b>Fast breathing</b> (in breaths/min): $< 2$ months: $> 60$ ; 2-11 months: $> 50$ ; 1-5 years: $> 40$ .	b. Children with any hypotension (SBP $< 5$ th centile or $> 2$ SD below normal for age) or two or three of the following: altered mental status; bradycardia or tachycardia (HR $< 90$ bpm or $> 160$ bpm in infants and heart rate $< 70$ bpm or $> 150$ bpm in children); prolonged capillary refill ( $> 2$ sec) or weak pulse; fast breathing; mottled or cool skin or petechial or purpuric rash; high lactate; reduced urine output; hyperthermia or hypothermia.





请点击开始

START TRAZING



Username

Password

Forgot Password?

LOGIN

请点击进行注册

No account yet?

Register

Privacy Policy | Terms of Use

Register as...

You can register as Individual, Transportation, Business / Government Office, Barangay or Delivery Crew

Step 1 of 3 - Select type

点击此处

INDIVIDUAL

BUSINESS / GOVERNMENT OFFICE

BARANGAY

TRANSPORTATION

DELIVERY CREW

BACK TO LOGIN

TRAZE PRIVACY POLICY

A. INDIVIDUAL REGISTRATION

1. WHAT PERSONAL DATA WE COLLECT?

Traze App collects personal information that includes :

- User Name/ID
- Last Name
- First Name
- Cell Phone Number
- Address/ city/ country
- Scanned or visited establishment, businesses, government agencies or other individuals
- Picture of the individual saved locally in the mobile phone for identification

2. WHY WE PROCESS PERSONAL DATA AND THE LEGAL BASIS FOR OUR PROCESSING?

We only process your data for purposes that are objectively justified by TRAZE Contact Tracing application and only as stated in this Privacy Statement. We process this data with respect to your right to privacy, including the need to protect personal integrity and private life and to ensure that your personal data is adequately protected against the risk of loss, misuse and unintended alteration.

Unless you are offered the option to provide prior consent to our use of your data, we process your data pursuant to Mandatory Reporting of Notifiable Diseases and Health Events of Public Health

I AGREE 同意 CANCEL

Register

as Individual

Click to change type

Step 2 of 3 - Fill up the following fields.

Your data is safe with us

Note : Please put your real information as this will be used for contact tracing

自己设定用户名 - 英文拼音

Username (Required)

自己设定密码 (8位数字字母和数字)

Password (Required)

确认密码

Confirm Passw

本人名的拼音

First Name (Required)

本人姓的拼音

Last Name (Required)

本人手机号码 - \*

Contact No. (Required)

本人的电子邮箱

Email Address (Required)

点提交

SUBMIT

CANCEL

Registration

Please capture profile image

上传本人照片或自拍照

OK

NCR - Manila

SUBMIT

CANCEL

Capture Image

Captured image will not be sent to the server

继续

Continue

NCR - Manila

Confirm Password (Required)

First Name (Required)

Last Name (Required)

Contact No. (Required)

Confirmation 确认所有信息是真的和对

I certify that all information is true and correct.

Cancel 确认

Confirm

NCR - Manila

SUBMIT

CANCEL

Confirm Password (Required)

First Name (Required)

Last Name (Required)

Contact No. (Required)

ENTER THE VERIFICATION CODE GIVEN BELOW 输入验证码

2D3TVL

必须一模一样

Enter code 2D3TVL

SUBMIT

提交

Cancel

SUBMIT

CANCEL

Confirm Password (Required)

First Name (Required)

Last Name (Required)

Contact No. (Required)


Registration

Registration Complete. Please enter your Username and Password to activate your account.

OK

SUBMIT

CANCEL



Username 用户名

Password 密码

Forgot Password?

LOGIN

No account yet?

Register

Privacy Policy | Terms of Use

TRAZE

Step 3 of 3 - Account activation

Make sure that you are connected to the internet in order to activate your account

点

ACTIVATE ACCOUNT

TRAZE Uses RECURSIVE QR Code

点

点提交

SUBMIT

提交

Cancel

SUBMIT

Confirm Password (Required)

First Name (Required)

Last Name (Required)

Contact No. (Required)

ENTER THE VERIFICATION CODE GIVEN BELOW 输入验证码

2D3TVL

必须一模一样


Enter code 2D3TVL

SUBMIT

提交

Cancel

SUBMIT



Traze ID

Activation complete. Please re-login and start Trazing

成功, 重新登入

OK

LATEST NEWS

13 May 2020

MRT-3, now using Traze at the stations

You need to login to Times when you leave MRT-3 Station Entrance, Train Coach & Station Exit

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机场码 (TRAZE)

<https://www.traze.ph/download.php>



提前自行注册即可, 无时间限制!



Username 用户名

Password 密码

Forgot Password?

LOGIN

No account yet?

Register

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TRAZE

359Q2


Traze ID点击查看二维码

TRAZE ME

TRAZE QR CODE


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