



# Islamic Republic of Afghanistan Visa Application Form

<b>Personal Information</b>	
Title:	
Family Name:	
Given Names:	
Father's Full Name:	
Date of Birth (Gregorian): DD/MM/YYYY	
Country of Birth:	
<b>Level of Education</b>	
Degree: Specialization:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow/Widower	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child: (Under 18 years) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Country of Residence:	
Nationality:	
Other Nationalities:	
<b>Contact Details</b>	
Current Address:	
Email Address:	
Mobile:	Work Tel:
Home Tel:	Fax:
<b>Employment Details</b>	
Current Occupation:	
Employer's Name:	
Employer's Address:	
Previous Occupation:	
Previous Employer's Name:	
Previous Employer's Address:	

Visa Details	
Visa Type:	
Purpose of Visit: <input type="checkbox"/> Business <input type="checkbox"/> Convention/Conference <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Exhibition <input type="checkbox"/> Visiting Friends/Family <input type="checkbox"/> Holiday <input type="checkbox"/> Others	
Entry Date:	Point of Entry:
Intended Duration of Stay (Day):	Number of children Accompanied:
Places in Afghanistan intended to visit:	
Complete Address in Afghanistan:	
Have you ever visited Afghanistan before? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details:</i>	
Have you applied for Afghanistan Visa before? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details:</i>	
Do you have criminal records? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details:</i>	
Passport Details	
Passport Type:	Passport Number:
Place of Issue:	
Issue Date:	Expiry Date:
I declare that the information provided in this application is true and correct.	
<b>Signature:</b> <i>(please sign within the box)</i>  <div style="border: 1px solid black; width: 250px; height: 60px; margin: 0 auto;"></div>  Date: DD/MM/YYYY	<b>Passport Photograph:</b> <i>(please attach within the square bellow.)</i>  <div style="border: 1px solid black; padding: 5px;"> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 5px; width: 100px; text-align: center;">             Please attach photo here           </div> <div style="border: 1px solid black; padding: 5px; width: 100px;">             Guarantor must endorse the photo.               This is a true photo of:               _____           </div> </div> </div>



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HEALTH QUESTIONNAIRE			
<b>Have you ever had or are you under treatment for any of the following communicable diseases?</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No (if Yes, please indicate.)		
<input type="checkbox"/> Ebola	<input type="checkbox"/> Intro virus D68	<input type="checkbox"/> Flu	<input type="checkbox"/> Hanta Virus
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Measles	<input type="checkbox"/> MRSA Pertusis	<input type="checkbox"/> Rabies
<input type="checkbox"/> STD	<input type="checkbox"/> TB	<input type="checkbox"/> West Nile Virus	
<b>Declaration:</b>			
I, hereby, solemnly declare that all the information provided above are true and correct to the best of my knowledge.			
Date: DD/MM/YYYY	Signature: _____		

OFFICE USE ONLY	
<b>Receiving Office:</b>	
<b>Application Details:</b>	
Date of Application Received:	DD/MM/YYYY
Date of Application: DD/MM/YYYY	Visa Type:
<b>Comments:</b>	
<b>Observations:</b>	
<b>Passport Details:</b>	
Name:	Passport Number:
Visa Serial Number:	Issue By:
Issuing Office:	Date: DD/MM/YYYY
<b>Collected by/Send to:</b> (Note: if collected by someone other than the applicant, written authorization must be provided by the applicant and retained on file.)	