Exhibit C Form

TestResultC表-檢驗結果

StateofHawai'i

CertificateofTestingforCOVID-19

夏威夷州新冠肺炎(COVID-19)檢測證明

DateofIssue:2022/07/02

(發證日期)

Name_____

(姓氏)Family Name (名字)FristName (中間名) MiddleName

Nationality TAIWAN(R.O.C) Date ofBirth_____ PassportNo.

(國籍) (出生年/月/日) (護照號碼)

Address_____

(住址)

ScheduledDateandTimeofDeparture_____

(預計出發日期及時間)

This is to certify the following results which have been confirmed by RT-PCR testNegative2079242468 for COVID-19 conductedwiththesampletaken fromtheabove mentioned person.

茲證明以上此人經RT-PCR採驗的新冠肺炎(COVID-19)病毒檢驗結果為陰性。

Sample檢體取樣	Dateand Time日期及時間(年/月/日/時)	Remarks備註
■ Nasopharyngeal Swab(鼻咽拭子) □ Saliva (唾液)	Samplecollected2022/07/02 09:16 (採樣時間) Resultdetermined2022/07/02 15:14 (結果判定時間)	

Institution Hsinchu MacKay Memorial Hospital

(醫療機構名稱)

Address No. 690, Section 2, Guangfu Road, Hsinchu City 30071, Taiwan

(地址)

PhysicianName Kuo-Ming Chang, Dr.

(醫師姓名)

SignatureandDate 2022/07/02

簽章與日期(年/月/日)