Certificate of Health

Name:

Sex: Female Male Other

Date of Birth:

Department/Faculty:

Year: (M2)

|  |  |
| --- | --- |
| Clinical Appearance | Blood Type (if confirmed)Blood pressureColor blindnessLung (X-ray)CardiographyUrinalysisLiver function |
| Disease Currently Being Treated | (Regular medication, if any) |
| Past Illness | Tuberculosis and/or other communicable diseaseKidney diseaseHeart diseaseDiabetesPsychosisDrug allergy |
| Physician’s Observation |  |

In view of the applicant's history and the above findings, I certify that his/her health status is adequate to pursue studies in Japan.

Date:

Physician’s Signature:

(Name in Block)

Institution: