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**FORM: D**

# CERTIFICATE OF HEALTH

***(Please print out and must be completed by the examining physician)***

***This application form is required to submit to the Program Director only***

**Name of Examinee:**

Mr. /Mrs / Miss _____

*(Family name)* *(Given name)* *(Middle name)*

Gender: ☐ Male ☐ Female

Date of Birth: Date:_____ Month: _____ Year:_____ Age:_____

**1. Physical Examinations**

(1) Height :_____ cm Weight : _____ kg

(2) Blood Pressure:_____ mm/Hg _____ mm/Hg

| Blood Type : | ABO | RH+ | RH- |
|---|---|---|---|
| | | | |

(3) Pulse ☐ Regular ☐ Irregular

(4) Eyesight : (R) _____ (L) _____ Color Blindness ☐ Normal

(Without glasses) ☐ Impaired

(5) Hearing: ☐ Normal Speech : ☐ Normal
☐ Impaired ☐ Impaired

**2. Please describe the results of physical and X-ray examinations of applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).**

Lung: ☐ Normal ☐ Impaired

Describe the condition of applicant's lung.
……
……
……

Cardiomegaly: ☐ Normal ☐ Impaired

Electrocardiograph: ☐ Normal ☐ Impaired

**3. Disease Treated at Present** ☐ Yes (Disease:_____) ☐ No

**4. Past History: Please indicate (with + or –) and fill in the date of recovery**

☐ Tuberculosis (……) ☐ Malaria (……) ☐ Other communicable disease (……)
☐ Epilepsy (……) ☐ Kidney disease (……) ☐ Heart disease (……)
☐ Diabetes (……) ☐ Drug allergy (……) ☐ Psychosis (……)
☐ Functional disorder in extremities (……)

**5. Laboratory Tests:**

Urinalysis: Glucose_____ protein _____ occult blood _____
ESR: _____ mm/Hr, WBC count:_____ /cmm ☐ anemia

**6. Please describe your impression:** _____

**7. In view of the applicant's history and the above findings; is his/her health status adequate to pursue studies in graduate levels?** ☐ **Yes** ☐ **No**

Date: _____ Signature: _____
Physician's Name in Print :

| Office/Institution: | |
|---|---|
| Address: | |