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CERTIFICATE OF HEALTH

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

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) _____

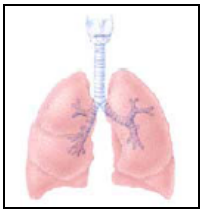
(Without glasses)

Color Blindness ☐ Normal
☐ Impaired

(5) Hearing: ☐ Normal
☐ Impaired

Speech : ☐ Normal
☐ 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 (……)
☐ Diabetes (……) ☐ Drug allergy (……) ☐ Heart disease (……)
☐ Functional disorder in extremities (……) ☐ Psychosis (……)

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:	