PLEASE PRINT CLEARLY

THE 2018 JAPAN EXCHANGE AND TEACHING (JET) PROGRAM

CERTIFICATE OF HEALTH

To be completed and signed by examining physician. Physician must not be a relative of applicant.

To the Examining Physician (*PLEASE READ THOROUGHLY*)

You are asked to evaluate the physical and mental health of the applicant for the JET Program. Participants of the JET Program will be assigned for one year to schools or to local government offices in Japan. It is extremely important that all participants be able to adjust to dramatic changes in climate, diet, and living conditions. Living and working overseas can also create ***emotional*** and ***physical*** stresses in response to the demands of living in a new and different environment. In some cases, mild disorders can become serious under the stress of life and work in foreign surroundings. It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history.

NOTE: An answer must be provided for Question 7. The applicant's file cannot be processed without this information. Failure to answer Question 7 will result in file processing delays and may even prevent an applicant from participating.

1. **Applicant's Name:** _____ _____ _____
   (*Last Name*) (*First Name*) (*Middle Name*)
   Date of Birth: M /D /Y **Age:** _____ **Sex:** ☐Male / ☐Female
2. **Physical Examination**
   (1) **Height:** _____ cm ／ inch **Weight:** _____ kg ／ lbs
   (*Please circle "cm" or "inch"*) (*Please circle "kg" or "lbs"*)
   (2) **Blood Pressure:** _____ mm/Hg ～ _____ mm/Hg
   Pulse Rate: _____ /min ☐regular / ☐irregular
   (3) **Eyesight:** (R) _____ (L) _____ (R) _____ (L) _____
   (*without glasses*) (*with glasses or contact lenses*)
   Colour Blindness: ☐normal / ☐impaired
   (4) **Hearing:** ☐normal / ☐impaired **Speech:** ☐normal / ☐impaired
3. **Urinalysis:** glucose ( ) protein ( ) occult blood ( )
4. **Past history:** Please indicate with X if applicant has ever had any of the following, and fill in the specific name of disorder and the date of recovery:
   ☐ Tuberculosis _____ (. .) ☐ Malaria _____ (. .)
   ☐ Other Communicable Disease _____ (. .)
   ☐ Epilepsy _____ (. .) ☐ Renal Disease _____ (. .)
   ☐ Cardiac Diseases _____ (. .) ☐ Diabetes _____ (. .)
   ☐ Drug Allergy _____ (. .) ☐ Functional Disorder in Extremities _____ (. .)
   ☐ Mental Disorder(s) (*including but not limited to ADD, ADHD, depression, anxiety, eating disorders, obsessive compulsive disorders*)
   _____ (. .)
   ☐ Other…. If yes, please specify: _____ (. .), _____ (. .)
5. **X-ray / TB Examination:** Applicants must submit results of **either an x-ray examination or a tuberculosis test.** Please describe the result of the applicants physical and chest X-ray examination (*X-ray(s) taken more than 3 months prior to the certification is NOT valid*). Results of tuberculosis test must be provided regardless of vaccination history if the necessary information is not completed below.

   Lung: ☐normal / ☐impaired
   Date of X-ray: _____ **Film No.:** _____
   Cardiomegaly: ☐normal / ☐impaired
   Describe the condition of applicant's lung:

   

   Date of TB test: _____
   Results attached: ☐
   Explanation:
6. Please add any other information, whether or not requested on this form, which might be pertinent to the applicant's ability to teach or take part in the activities of the JET Program (*eg. pregnancy, physical disability, drug addiction, etc.*).
7. In view of the applicant's history and the above findings, is it your observation his/her health status is adequate to go abroad to participate on the JET Program?

☐YES ☐NO

<MUST BE SIGNED BY A PHYSICIAN WITH A DOCTORATE IN MEDICINE (M.D.)>

Date: _____ Physician's Signature: _____

Physician's Name in Print: _____

Office/Institution: _____

Address: _____

TEL: _____ FAX: _____ E-mail: _____