THE JAPAN EXCHANGE AND TEACHING PROGRAM
2020 SELF-REPORT OF MEDICAL CONDITIONS

Name of Applicant: _____
(as printed in passport) Last Name First Name Middle Name

Interview Location: _____**Date of Birth:** _____

Your application cannot be processed without this form. It is important that you submit accurate information regarding your medical history. This information will be used when assigning your placement as well as in serving as a quick reference should any medical emergencies arise while you are participating in the program.
If you suffer, or have ever suffered from any physical or mental illness, please attach an explanation from your physician, using the 2020 Physician's Form, stating whether you are fit to participate in the 2020 JET Program and, as such, to live and work overseas.

1. Current Treatment of Any Physical Conditions
Are you currently seeing a physician and/or undergoing treatment? (except for colds, fevers, visiting OB/GYN facilities, or consultations for requesting contraception)? If yes, you must provide details as to when, why, the duration of treatment below AND have your doctor fill out the Physician's Form.

2a. Physical Condition(s) in the Past Five (5) Years
What serious diseases, injuries and/or medical conditions have you had **in the past five years**? If any of these resulted in hospitalization, please give details as to when, why, and the duration of treatment below AND have your doctor fill out the Physician's Form.

2b. Other Undisclosed Conditions
Other than those stated in 2a., have you ever been treated for any other serious diseases, injuries, and/or medical conditions, including but not limited to heart disease, blood disease, auto immune disease, cancer, epilepsy, congenital disease, recurrent disease, or any other disease, injury, or medical condition involving permanent damage? If yes, you must provide details below AND have your doctor fill out the Physician's Form.

3. History of Nervous or Mental Conditions in Your Lifetime
Have you ever suffered from any nervous or mental disorders? If yes, you must provide details below AND have your doctor fill out the Physician's Form. Please note that we may contact your doctor if further information is necessary.

□ Anxiety	□ Depression	□ Obsessive-Compulsive Disorder
□ Bipolar Disorder	□ Attention Deficit Disorder	□ Attention Deficit/Hyperactivity Disorder
□ Eating Disorder	□ Post-Traumatic Stress Disorder (PTSD)	□ Other ( )

4. Foreseeable Difficulty in Navigating Stairs
Do you foresee any physical challenges resulting from the need to go up and down several flights of stairs on a daily basis? If yes, please explain.

5. Allergies
What allergies do you have, if any? Are you currently undergoing treatment? If yes, provide details.

6. Medications
If you are currently taking, or have taken in the last five years, any prescription medication, other than oral contraceptives, please give details including the name of the medication, purpose, and dates taken. Make sure to describe the conditions for which you take any medications listed here in questions 1, 2a., 2b., 3, above.

7. Eyesight and Hearing
Are you color blind or do you have any disabilities related to your eyesight or hearing? (Excluding the use of prescription glasses and contact lenses to correct vision) If yes, please provide details. If you have a driver's license, please describe whether it affects your ability to drive.

□ Legally Blind □ Colorblindess □ Hearing Impaired

If you provided information for question 7 and have a driver's license, does this affect your ability to drive?
☐ Yes ☐ No

8. Dietary Restrictions
Are there any foods or substances which, for medical or personal reasons, you do not eat? If so, please give details (e.g. medical, religious, personal reasons, etc.).

Food				**Reasons**
□ Beef	□ Chicken	□ Dairy Products	□ Eggs	□ Allergies
□ Gluten	□ Tree Nuts	□ Peanuts	□ Pork	□ Religion
□ Wheat	□ Shellfish	□ Soy (		□ Other medical reasons
□ Finfish	□ Fruit	□ Other (	)	□ Other ( )

9. Other Health Related Issues or Disabilities
Please explain any other health-related issues/ disabilities (e.g. confined to wheelchair, pending medical treatment, etc.)

10. Tattoos or Piercings / Miscellaneous
Candidates who have tattoos and/or body piercings, please provide details of the tattoos, including location and size.

I understand that false statements may result in disqualification from the Programme.
I also understand that if I suffer, or have ever suffered from any physical or mental illness, I must also submit the Physician's Form in which my physician clearly states my ability to live and work overseas on the JET Program.

Applicant's Signature: _____ Date: _____