



**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

Cardiomegaly:  Normal  
 Impaired

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

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**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Tuberculosis (.....)                       | <input type="checkbox"/> Malaria (.....)        | <input type="checkbox"/> Other communicable disease (.....) |
| <input type="checkbox"/> Epilepsy (.....)                           | <input type="checkbox"/> Kidney disease (.....) |   |
| <input type="checkbox"/> Diabetes (.....)                           | <input type="checkbox"/> Drug allergy (.....)   | <input type="checkbox"/> Heart disease (.....)              |
| <input type="checkbox"/> Functional disorder in extremities (.....) |   | <input type="checkbox"/> 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:            |  |