様式第3-B号（第2条第1項第3号関係）

CERTIFICATE OF HEALTH

Name of Applicant（in Roman block capitals）_____

Sex（ M ・ F ）　　Age _____　　Date of Birth _____ - _____ - _____

Present Address _____

Height_____(cm)　Weight_____(kg)

1. SENSE SYSTEM

Eye Sight　Right _____ (_____)

Left _____ (_____)

Color Blindness　Normal / Abnormal

Hearing　Normal / Abnormal

2. RESPIRATORY SYSTEM

Medical Judgment　Normal / Abnormal

Chest X-Ray Examination

Condition of Applicant's Lungs

Normal / Abnormal

Film No. _____

3. CIRCULATORY SYSTEM

Medical Judgment　Normal / Abnormal

(Heart Murmur　Normal / Abnormal)

Blood Pressure sys. _____ / _____ dia.

Condition of Applicant's Heart

(cf. Above Graph)

Normal / Doubtful / Abnormal

4. URINE TEST

Sugar_____　Protein_____

(please indicate with ＋, if you find any disease or abnormality, or with －, if not)

5. BLOOD TEST

Blood Type: _____

ESR (Erythrocyte Sedimentation Rate)

1 hour later: _____mm

2 hours later: _____mm

GOT（AST）: _____unit

GPT（ALT）: _____unit

6. DECAYED TOOTH

Untreated_____　Treated_____

7. Allergy, if any

(　) No / (　) Yes

What is applicant allergic to? (　　)

8. Previous History

9. Total Judgment for Applicant's Health

Name & Title of Physician _____

Address _____

Date _____ - _____ - 20_____　Signature _____