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. Allergies

8. Previous History

9. Total Judgment for Applicant's Health

Name & Title of Physician ______________________________

Address ______________________________

Date ________ - ________ - 20 ________   Signature ______________________________