## CERTIFICATE OF HEALTH

Name of Applicant (in Ro	man block capitals)	
Sex(M·F)	Age	Date of Birth
Present Address		
Height(cm)  1. SENSE SYSTEM  Eye Sight Right _	Weight(kg)	4. URINE TEST  Sugar Protein  (please indicate with +, if you find any
Left _	()	disease or abnormality, or with $-$ , if not)
Color Blindness Hearing	Normal / Abnormal Normal / Abnormal	5. BLOOD TEST  Blood Type:  ESR (Erythrocyte Sedimentation Rate)
2. RESPIRATORY SYSTEM		1 hour later:mm
Medical Judgment	Normal / Abnormal	2 hours later:mm
Chest X-Ray Examination		GOT (AST) :unit
Condition of Applicant's Lungs		GPT (ALT) :unit
Film No.	Normal / Abnormal	6. DECAYED TOOTH  Untreated Treated
3. CIRCULATORY SYSTEM		
Medical Judgment (Heart Murmur Blood Pressure sys	· ·	7. Findings of other tests, if any 8. Previous History
Condition of Applicant's Heart  (cf. Above Graph)  Normal / Doubtful / Abnormal		9. Total Judgment for Applicant's Health
Name & Title of Physicia Address		
Date	- 20	Signature