様式第5-B号（第2条第1項第5号及び第14条第2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 __________