様式第 3-B 号（第 2 条第 4 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

Eyesight Right_____(_____)

Left_____(_____)

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 Pressurizes. _____/_____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

Precipitation of Blood

1 hour later _____ mm

2 hours later_____ mm

GOT _____ unit

GPT _____ unit

Syphilis _____

6. DECAYED TOOTH

Untreated _____ Treated _____

7. Findings of other tests, if any

8. Previous History

9. Total Judgment for Applicant's Health

Name & Title of Physician _____

Address _____

Date _____ Signature _____