- 2012 Japan Exchange and Teaching Program -

CERTIFICATE OF HEALTH

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Part I. *To be completed by the **applicant** before visiting his/her physician.*

NAME ________________________________ ______________________________ ____________________
Last First Middle

DATE OF BIRTH ____/____/19____ **AGE** ____________ **SEX: M / F**
MM/DD/YYYY

Part II. *To be completed and signed by the **physician.** The physician must not be a relative of the applicant.*

TO THE PHYSICIAN: You are requested to evaluate the physical and mental health of the above-mentioned applicant for selection for the Japan Exchange and Teaching (JET) Program. Participants of this program will be employed for one year in schools or local government offices in Japan.
It is extremely important that all participants are able to adjust to dramatic changes in climate, diet, and living conditions. Living overseas can also create emotional and physical stress in response to the demands of living in a new and different environment. In some cases, mild disorders can become serious under the stress of life in foreign surroundings and the influence of culture shock.
It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history.
NOTE: An answer must be provided for Question F. The applicant's file cannot be processed without this information. Failure to answer Question F will result in file processing delays and may even prevent an applicant from participating.

A. Physical Examination

(1) Height: ___________________cm Weight: ___________________kg

(2) Blood Pressure: ___________mm/Hg ~ ___________mm/Hg

Pulse Rate: _______________/min ☐ regular / ☐ irregular

(3) Eyesight: (R)___________(L)___________ (without glasses) (R)___________(L)___________ (with glasses or contact lenses)

Color Blindness: ☐ normal / ☐ impaired

(4) Hearing: ☐ normal / ☐ impaired Speech: ☐ normal / ☐ impaired

B. Urinalysis: glucose ( ) protein ( ) occult blood ( )

C. Past History: Please indicate with an "X" if applicant has ever had any of the following. Also fill in the specific name of the disorder and the date of recovery:

☐ Tuberculosis ____________________________ ☐ Malaria ____

☐ Other communicable diseases ____

☐ Epilepsy _________________________________ ☐ Renal Disease ______________________________________

☐ Cardiac Diseases _________________________ ☐ Diabetes ____

☐ Drug Allergy _____________________________ ☐ Psychosis ____

☐ Functional disorder in extremities ____

☐ Other(s)--please specify the name and the date of recovery. ____

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D. Lung/TB Examination: Applicants must submit results of either an x-ray examination or a tuberculosis test. Please describe the results of a physical and X-ray examination of the applicant's chest. Please note the exact date of the X-ray. (An X-ray taken more than three months prior to the completion of this Certificate of Health is **NOT** acceptable.) Results of a tuberculosis test must be provided if the x-ray information is not completed below.

Date of X-ray:____________________ Film No.___________________

Lungs: ☐ normal / ☐ impaired

Cardiomegaly: ☐ normal / ☐ impaired

Describe the condition of the applicant's lungs:

E. Please add any other information, whether or not it has been requested elsewhere on this form, which might be pertinent to the applicant's ability to teach or take part in the activities of the JET Program (i.e. pregnancy, physical defect, drug addiction, etc.).

F. In view of the applicant's medical history and the above findings, is it your observation that the applicant's health status is adequate to go abroad to participate in the JET Program?

☐ YES / ☐ NO

NAME of physician completing this form: ____
(Please print)

OFFICE / INSTITUTION NAME: ____

ADDRESS: ____

____

TELEPHONE: ______________________________ **FAX:** ______________________________

E-MAIL (if applicable)**:** ____

SIGNATURE: ______________________________ **DATE:** ____________________