CERTIFICATE OF HEALTH (to be filled out by a physician)

N	AME OF APPLICANT (in block capitals)			SEX	FJ ~	AGE	DATE O	DATE OF BIRTH		
				M.	F.					
P	RESENT ADDRE	ESS								
1.	Height		Weight _							
	Blood Pressure	Blood Pressure Sys I					<u> </u>			
	Pulse Rate	/m Reg.	. Irreg.	_						
	Reflexes	: Pupil <u>Normal</u>	, Abnormal	Knee	:Norr	nal , Abı	normal			
		Others ():Normal	, Abnormal	_					
	Eye-Sight :	Left	Right	Color-Bl	indness		Hearing			
	without glasses			_ Yes	: ()	:Normal ,	Abnormal		
_										
2.	Anamnesis : please indicate with + or - Tuberculosis Malaria. Epilepsy Kidney Diseases			Rheumatic Fever						
				Cardiac Diseases						
	Diabetes Allergy			Other Communicable Diseases						
3.	Present Conditions : Please indicate with +, if you find any disease or abnormality, or with -, if not.									
	Tonsils, Nose or Throat			Heart or Blood Vessels						
						Stomach or Digestive				
	Lungs or Respiratory System Genitourinary System Brain or Nervous System Bones, Joints or Locomotor System			Other Abdominal Organs						
				Blood or Endocrine System						
				Skin						
5.	Describe in full	on conditions of appl	icant s lungs: (Inclu	iding the result	of Ches	t X-ray exam	ination and its date)		
6.	Has the applican	nt ever suffered from a	any nervous or ment	al disorder?						
7. In my opinion, the applicant s health and physical conditions are (Please check the approximately seed to be approxima							opriate box.)			
	Evcellent		Good	Fo	ir		Poor	:		
8	Excellent Good Fair Poor In my opinion, the applicant is physically able to go abroad for study (Please check the appropriate bo									
٠.										
	Yes	No	NAME	E & TITLE OF PHYSICIAN (Please print.)						
		ADDI	ADDRESS							
SI				SIGNATURE / SEAL						
D	ATE									
		ay month	year							