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

NAME OF APPLICANT (in block capitals)	SEX M. F.	AGE	DATE OF BIRTH
PRESENT ADDRESS			

1. Height _____ Weight _____
   Blood Pressure Sys. _____ Dia. _____ .
   Pulse Rate _____ /m Reg. . Irreg.
   Reflexes : Pupil Normal , Abnormal Knee :Normal , Abnormal
   Others ( ):Normal , Abnormal
   Eye-Sight : Left Right Color-Blindness Hearing
   without glasses _____ _____ Yes: ( ) :Normal , Abnormal

2. Anamnesis : please indicate with + or - + -

Tuberculosis	Malaria.	Rheumatic Fever
Epilepsy	Kidney Diseases	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		
Lungs or Respiratory System			Stomach or Digestive		
Genitourinary System			Other Abdominal Organs		
Brain or Nervous System			Blood or Endocrine System		
Bones, Joints or Locomotor System			Skin		

4. If you marked + to any of the above 2 and 3, please describe in detail each disease, and if the applicant is physically handicapped, the abnormality or impairment.
   2 3 +

5. Describe in full on conditions of applicant s lungs: (Including the result of Chest X-ray examination and its date)

6. Has the applicant ever suffered from any nervous or mental disorder?

7. In my opinion, the applicant s health and physical conditions are (Please check the appropriate box.)
   :
   Excellent Good Fair Poor

8. **In my opinion, the applicant is physically able to go abroad for study** (Please check the appropriate box.)

   Yes **No**

NAME & TITLE OF PHYSICIAN (Please print.)

_____

ADDRESS

_____

SIGNATURE / SEAL

_____

DATE _____
day **month** **year**