- 2016 Japan Exchange and Teaching Program -
CERTIFICATE OF HEALTH

To be completed and signed by the examining physician. Physician must not be a relative of the applicant. Please note that a Physician's Assistant can fill out this form, but it must be co-signed by the attending physician.

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 and working overseas can also create emotional and physical stress in response to the demands of living in a new and different environment. It is therefore essential that your reply be based on a current and thorough physical and mental examination as well as your knowledge of the applicant's medical history.

NOTE: An answer must be provided for Question 7. The applicant's file cannot be processed without this information. Failure to answer Question 7 will result in file processing delays and may even prevent an applicant from participating.

1. Name:_____ _____ _____
Last *First* *Middle*

Date of Birth ____/____/19____ **AGE** _____ **SEX: M / F**
MM / DD / YYYY *Circle one of the above*

2. Physical Examination

(1) Height: _____cm Weight: _____kg

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

Pulse Rate: _____/min ☐ regular / ☐ irregular

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

Color Blindness: ☐ normal / ☐ impaired

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

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

4. **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 _____ ☐ Mental Illness/Impairment _____

☐ Functional disorder in extremities _____

☐ Other(s)--please specify the condition and the date of recovery. _____

5. **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, including the date taken..(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._____ OR Date of TB test:_____

Lungs: ☐ normal / ☐ impaired Results attached: / ☐

Cardiomegaly: ☐ normal / ☐ impaired Explanation:

Describe the condition of the applicant's lungs:

6. Please add any additional 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.).

7. **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

Please print the information below clearly and sign and date this form. Thank you for your assistance!

NAME of physician completing this form: _____

LENGTH OF TIME YOU HAVE KNOWN/TREATED THE APPLICANT: _____

Please circle one:

SPECIALIZATION/AREA OF EXPERTISE: _____ **MD/DO/APRN/Other**:_____

OFFICE / INSTITUTION NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____ **FAX:** _____

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

SIGNATURE: _____ **DATE:** _____