PLEASE PRINT CLEARLY

THE 2024 JAPAN EXCHANGE AND TEACHING (JET) PROGRAMME

CERTIFICATE OF HEALTH

To be completed and signed by examining physician. Physician must not be a relative of applicant.

To the Examining Physician (*PLEASE READ THOROUGHLY*)

You are asked to evaluate the physical and mental health of the applicant for the JET Programme. Participants of the JET Programme will be assigned for one year to schools or to local government offices in Japan. It is imperative that all participants be able to adjust to dramatic changes in climate, diet, and living conditions. Living and working overseas can also create ***emotional*** and ***physical*** stresses in response to the demands of living in a new and different environment. In some cases, mild disorders can become serious due to the stress of life and work in foreign surroundings. It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history.

NOTE: PLEASE FILL IN ALL SECTIONS. ANY MISSING INFORMATION INCLUDING QUESTION 7 MAY HINDER OR PREVENT A CANDIDATE FROM PARTICIPATING.

1. **Applicant's Name:** _____ (*Last Name*) _____ (*First Name*) _____ (*Middle Name*)
   Date of Birth: D____/M____/Y____ **Age:** _____ **Sex:** □ Male / □ Female / □ Other

2. **Physical Examination** **Height:** _____ **Weight:** _____
   Blood Pressure: _____mm/Hg / _____mm/Hg **Pulse Rate:** _____ /min
   □ regular / □ irregular
   Eyesight: (R)_____(L)_____(*without glasses or contact lenses*)
   (R)_____(L)_____(*with glasses or contact lenses*)
   Colour Blindness: □ normal / □ impaired (**If impaired**, OK to drive: □) **Hearing:** □ normal / □ impaired (**If impaired**, OK to drive: □)

3. **Urinalysis:** glucose ( ) protein ( ) occult blood ( ) (neg, +2, -, etc.)

4. **Medical History:** Please mark any items below that the applicant has ever been diagnosed with. Fill in the name of the disorder and, if applicable, the date of recovery. If none of the conditions below apply, please check NONE: ☐ **NONE**

□ Tuberculosis_____ (MM/YYYY) □ Malaria_____ (MM/YYYY)
□ Other Communicable Disease_____ (MM/YYYY)
□ Epilepsy_____ (MM/YYYY) □ Renal Disease_____ (MM/YYYY)
□ Cardiac Disease_____ (MM/YYYY) □ Diabetes_____ (MM/YYYY)
□ Drug Allergy_____ (MM/YYYY) □ Functional Disorder in Extremities_____ (MM/YYYY)
□ Mental Disorder(s) (*including but not limited to ADD, ADHD, depression, anxiety, eating disorders, obsessive compulsive disorders*)
_____ (MM/YYYY)
□ Other (please specify)_____ (MM/YYYY) _____ (MM/YYYY)

5. **X-ray Examination/Tuberculosis Test:** Please describe the result of the applicant's physical and chest X-ray examination (*X-rays taken more than 3 months prior to this certificate are NOT valid*). Results of a tuberculosis test must be provided regardless of vaccination history if the X-ray information is not completed below. (*Tuberculosis tests taken more than 3 months prior to this certificate are NOT valid*). **Please note: As a rule, all applicants who test positive in a PPD test, regardless of chest X-ray results, MUST SUBMIT A BLOOD TEST OR TAKE DRUGS TO SUPPRESS TUBERCULOSIS BEFORE COMING TO JAPAN.**

Lungs: □ normal / □ impaired **Date of Tuberculosis Test:** _____
Date of X-ray: _____ **Results:** □ Positive / □ Negative
Cardiomegaly: □ normal / □ impaired **Results attached:** □
Describe the condition of applicant's lungs:

6. Please indicate any other information, whether or not requested on this form, which may be pertinent to the applicant's ability to teach or take part in the activities of the JET Programme (*e.g., pregnancy, physical disability, drug addiction, etc.*). ☐ **NONE**

7. In view of the applicant's history and the above findings, is it your observation his/her health status is adequate to go abroad to participate on the JET Programme? ☐ **YES** ☐ **NO**

<MUST BE SIGNED BY A PHYSICIAN WITH A D.O. or M.D>

Date: _____ Physician's Signature: _____
Physician's Name in Print: _____
Office/Institution: _____
Address: _____
TEL: _____ FAX: _____ E-mail: _____