

2019 JET Programme Applicant Self-Report of Medical Condition(s)
(健康状況自己報告書)

Interview Location: _____
(面接地)

To the applicant: Please fill out the reference data below. Your application cannot be processed without this form. Successful applicants will be required to submit a JET Programme Certificate of Health, including a chest X-ray, from their physician by the date designated by the Embassy or Consulate General of Japan. **It is important that you submit correct information regarding your medical history. If you now have or have ever had any physical or mental condition/illness, your physician must attach a statement to provide an explanation indicating whether you are fit to participate on the JET Programme and to live and work overseas.** This information will be used to your benefit in deciding your contracting organisation as well as in serving as a quick reference should any medical emergencies arise while you are participating on the JET Programme.

(**申請者へ**：下記に記入のこと。本フォームの提出がないと申請手続きが進められません。合格者は、胸部X線を含むJETプログラム健康診断書を日本大使館または総領事館が指定する期日までに提出することが求められます。自身の医療歴について正確に申請することが重要です。現在、または過去に身体的及び精神的疾患を有する場合、JETプログラムに参加し、海外で勤務・生活することが可能かどうかを示す医師の報告書を添付する必要があります。本情報は任用団体の決定に使用されるとともに、JETプログラム参加中に医療的緊急事態が発生した際に参照されます。)

PERSONAL DETAILS (応募者詳細)		
DATE OF BIRTH: M (月) /D (日) /Y (年) (生年月日) / /		
NAME (氏名) ※ <i>as printed on your passport</i> (パスポート通りに記載)		
Last (姓)	First (名)	Middle (ミドルネーム)

1. Are you currently seeing a physician and/or undergoing treatment? (except for colds, fevers, visiting OB/GYN facilities, or consultations for requesting contraception). If yes, you must provide details as to when, why, the duration of treatment below AND have your doctor fill out the Statement of Physician.
(現在診察や治療や薬物治療を受けているか(風邪, 発熱, 婦人科または避妊の相談を除く)。該当する場合, 詳細(時期, 事由, 治癒の時期)を明記し, 医師の報告書を添付すること。)

- 2a. What serious diseases, injuries and/or medical conditions have you had in the past five years? If any of these resulted in hospitalisation, please give details as to when, why, and the duration of treatment below AND have your doctor fill out the Statement of Physician.
(過去5年間にどのような深刻な病気, 怪我または病態となったか。結果として, 入院した場合には, 詳細(時期, 事由, 治療の期間)を以下に明記し, 医師の報告書を添付すること。)

- 2b. Other than those stated in 2a., have you ever been treated for any other serious diseases, injuries, and/or medical conditions, including heart disease, blood disease, auto immune disease, cancer, epilepsy, congenital disease, recurrent disease, carrier conditions (for example, hepatitis), or any other disease, injury, or medical condition involving permanent damage? If yes, you must provide details below AND have your doctor fill out the Statement of Physician.
(2aに明記した以外で, 過去に心疾患, 血液疾患, 自己免疫疾患, 癌, てんかん, 先天性疾患, 再発性のある病気, キャリア状態の病気(肝炎等), 現在に後遺症が残る病気及び怪我を含む深刻な病気や怪我または病態で治療を受けたことがあるか。該当する場合には, 詳細を明記し, 医師の報告書を添付すること。)

3. If you have ever suffered from any nervous or mental disorders (including, but not limited to anxiety, depression, ADD, ADHD, eating disorders, etc.) you must provide details below AND have your doctor fill out the Statement of Physician. Please note that we may contact your doctor if the statement is incomplete or if further information is required.
 (過去に神経性または精神的疾患(例: 不安神経症, 鬱病, ADD, ADHD, 摂食障害等)にかかったことがあるか。もしあるなら, 詳細を明記し, 医師の報告書を添付すること。必要時には医師への問い合わせを行う旨をご了承ください。)
- anxiety (不安神経症) depression (鬱病) obsessive-compulsive disorder (脅迫神経症)
 bipolar disorder (双極性障害) ADD ADHD
 eating disorders (摂食障害) PTSD other (その他)()
- Please, provide details below (詳細を記入)

4. Do you foresee any physical challenges resulting from the need to go up and down several flights of stairs on a daily basis?
 If yes, please explain.
 (数階分の階段の昇降による身体的問題が予測されるか。ある場合は詳細を説明すること。)

5. Do you have any allergies? If yes, are you currently undergoing treatment?
 (アレルギー症があるか。該当する場合に, 治療は受けているか。詳細を以下に明記すること。)

6. If you are currently taking, or have taken in the last five years, any prescription medication, *other than oral contraceptives*, please give details including the name of the medication, purpose, and dates taken. Make sure to describe the conditions for which you take any medications listed here in questions 1, 2a., 2b., 3, above.
 (現在または過去5年間に薬物治療を受けている場合(ただし, 経口避妊薬を除く。), 薬品の名前, 目的, 服用頻度も含めてその詳細を記入すること。なお, 上記の設問1, 2a, 2b, 3で挙げた状況に対する処方箋についても明記ありたい。)

7. Are you colour blind or have any disabilities related to your eyesight or hearing? (Excluding the use of prescription glasses and contact lenses to correct vision)
 (視覚障害、色盲、聴覚障害で該当するものがあるか。(眼鏡、コンタクトレンズの使用により矯正済みの場合を除く。) 該当する場合は、詳細を明記すること。運転免許保持者は、運転に支障がないか記入すること。)
- legally blind (視覚障害) colour blindness (色盲) hearing impaired (聴覚障害)
- Please, provide details below (詳細を記入)

If you wrote anything for question 7 and have a driver's license, does this affect your ability to drive? Yes No

8. Are there any foods or substances which, for medical or personal reasons, you do not eat? If so, please give details (e.g. medical, religious, personal reasons, etc.).
 (現在食事制限を受けている場合, その詳細を記入すること。例: 疾病, 宗教的, 個人的な理由等)
- Foods:**
- Beef (牛肉) Chicken (鶏肉) Dairy Products (乳製品) Eggs (卵)
 Gluten (グルテン) Tree Nuts (ナッツ類) Peanuts (ピーナッツ) Pork (豚肉)
 Wheat (小麦) Shellfish (貝類・甲殻類) Soy (大豆)
 Finfish (魚類) Fruit (果実) Others (その他) ()
- Reasons:**
- Allergies (アレルギー) Other medical reasons (その他の疾病のため)
 Religion (宗教的) Other (その他) ()

9. Please explain any other health-related issues or disabilities below (e.g. confined to wheelchair, pending medical treatment, etc.).
 (その他の健康上の注意事項及び障害について以下に記入すること。例: 車いすの使用, 治療中の事項等)

- (タトゥーやピアスがある場合, その詳細を記入)
- Tattoos (タトゥー) Number (数) Location (箇所) Size (大きさ)
 Body piercings (ピアス) Number (数) Location (箇所) Size (大きさ)

The answers I have given are correct to the best of my knowledge.
 (申告書の記載事項のとおり相違ありません。)

Signature: (署名)	Date: (日付)
--------------------	---------------