PLEASE PRINT CLEARLY

THE 2025 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 a minimum of one year to schools or 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: DD / MM / YYYY **Age:** _____ **Sex:** □ Male / □ Female / □ Other

2. **Physical Examination:**

   Height: _____ cm **Weight:** _____ kg

   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)

□ Dyslexia (*Please include details of any complications or educational support for reading and writing handwritten/typed text*)

_____ (MM/YYYY)

□ Other (*Please specify*)_____ (MM/YYYY) _____ (MM/YYYY)

5. X-ray Examination or 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 MUST SUBMIT A BLOOD TEST OR TAKE DRUGS TO SUPPRESS TUBERCULOSIS BEFORE COMING TO JAPAN.

Date of X-ray: (DD/MM/YYYY) **Date of Tuberculosis Test:** (DD/MM/YYYY)

Lungs: □ normal / □ impaired **Results:** □ positive / □ negative

Cardiomegaly: □ normal / □ impaired **Results attached:** □

Describe the condition of applicant's lungs: _____

6. Other: Please indicate any other information, whether requested on this form or not, 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. Health Observation: In view of the applicant's history and the above findings, is it your observation their 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: _____