

- ☐ Drug Allergy _____ (MM/YYYY)
- ☐ Functional Disorder in Extremities _____ (MM/YYYY)
- ☐ Mental Health Disorder (*including but not limited to anxiety, depression, eating disorders, OCD, etc.*)
_____ (MM/YYYY)
- ☐ Developmental Disorder (*including but not limited to ADD/ADHD, autism, etc.*)
_____ (MM/YYYY)
- ☐ Learning Disability (*including but not limited to dyslexia, dysgraphia, etc.*)
*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 submit results of a chest X-ray examination, PPD (skin) test, or blood test. For X-ray examination, please describe the result of the applicant's chest exam and the condition of the applicant's lungs. Attaching a scan of X-ray results is not required.

Results of an x-ray examination or tuberculosis test must be provided regardless of vaccination history.
(IMPORTANT: X-rays or 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 NEGATIVE BLOOD TEST OR FINISH THE COURSE OF 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 that their health status is adequate to move abroad to participate in the JET Programme? ☐ **YES** ☐ **NO**

Must be signed by a health care provider licensed to diagnose and prescribe:
M.D. or G.P. preferred; D.O. or N.P. only where authorised.

Date: _____ Physician's Signature: _____

Physician's Name in Print: _____

Office/Institution: _____

Address: _____

TEL: _____ FAX: _____ E-mail: _____