NO. _____

HEALTH CERTIFICATE

☐ Male
☐ Female

NAME : _____ _____

DATE OF BIRTH : _____

ADDRESS : _____

THE EXAMINATION RESULTS ARE AS FOLLOWS :

HEIGHT : _____ cm WEIGHT : _____ kg BMI : _____

PAST HISTORY : _____

GENERAL PHYSICAL : _____

CHEST X-RAYS : _____

BLOOD PRESSURE : _____ ～ _____ mmHg ECG: _____

BLOOD TYPE : Rh _____ SERUM SYPHILIS REACTION: _____

HBs-Ag : _____ IU/mL HBs-Ab : _____ mIU/mL HCV-Ab : _____ HIV : _____

URINALYSIS : ALBUMIN _____ SUGAR _____ UROBILINOGEN _____

EYESIGHT : R. _____ L. _____ (CORRECTED TO R. _____ L. _____)

EYE DISEASE : _____ COLOR RECOGNITION: _____

EAR, NOSE & THROAT : _____ HEARING: _____

DATE OF EXAMINATION : _____

SUGGESTION :

_____

DOCTOR'S SIGNATURE:

DR. _____

SEAL OF DIRECTOR

DATE : _____

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