

- ☐ 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 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 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 that their health status is adequate to go abroad to participate in 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: _____