# HEALTH CERTIFICATE

**(Please put "√" in relevant cage)**

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|---|---|---|---|
| **Name :** | **Sex:** Male ☐ Female ☐ | **Date of Birth :** | **PHOTO** |
| **Postal address :** | | | |
| **Nationality :** | **Place of Birth :** | **Blood group:** | |

**Have you ever had any of the following diseases?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Typhus fever | ☐ | ☐ | Bacillary dysentery | ☐ | ☐ |
| Poliomyelitis | ☐ | ☐ | Brucellosis | ☐ | ☐ |
| Diphtheria | ☐ | ☐ | Viral hepatitis | ☐ | ☐ |
| Scarlet fever | ☐ | ☐ | Typhoid and paratyphoid fever | ☐ | ☐ |
| Relapsing fever | ☐ | ☐ | Epidemic cerebrospinal meningitis | ☐ | ☐ |

**Do you have any of the following diseases or disorders endangering the public order and security?**

| | Yes | No |
|---|---|---|
| Toxico mania | ☐ | ☐ |
| Mental confusion | ☐ | ☐ |
| Psychosis: Manic psychosis | ☐ | ☐ |
| Paranoid psychosis | ☐ | ☐ |
| Hallucinatory | ☐ | ☐ |

| | | |
|---|---|---|
| **Height :** cm | **Weight:** kg | **Blood pressure:** mmHg |
| **Development:** | **Nourishment:** | **Neck:** |
| **Vision:** | **Corrected vision:** | **Eyes:** |
| **Colour sense:** | **Skin:** | **Lymph nodes:** |
| **Ears:** | **Nose:** | **Tonsils:** |
| **Heart:** | **Lungs:** | **Abdomen:** |

| | | | |
|---|---|---|---|
| **Spine:** | **Extremities:** | | **Nervous system:** |
| **Other abnormal findings** | | | |
| **Chest X-ray exam** | | **ECG** | |
| **Laboratory exam for HIV/AIDS**<br>(Please attach test report of HIV/AIDS, Syphilis etc.) | | | |

**None of the following diseases or disorders found during the present examination.**

| | | | |
|---|---|---|---|
| Cholera | ☐ | Venereal Disease | ☐ |
| Yellow fever | ☐ | Lung tuberculosis | ☐ |
| Plague | ☐ | HIV/AIDS | ☐ |
| Leprosy | ☐ | Psychosis | ☐ |

| | |
|---|---|
| **Suggestion:** | **Signature of the physician** |
| **Date** | **Official Stamp** |