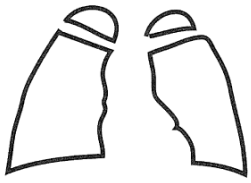
※Office use only

Physical Examination Certificate

Josai International University

Name		Result	no exam / re-exam / detailed exam
Date of birth	Year Month Day	☐ Male ☐ Female	Nationality
Address	TEL: ( )		

Chest X-ray Examination	Date of Examination Direct / Indirect No. _____ 	Eye-sight	R (Without Glasses) . (With Glasses) (.)
			L (Without Glasses) . (With Glasses) (.)
	Condition of lungs	Hearing	R ☐(Normal) ☐(Abnormal)
			L ☐(Normal) ☐(Abnormal)

Diagnosis of health and physical condition	Describe other disability or abnormality

I hereby certify that the above diagnosis is true and correct.

Year Month Day

Physician's Address

Telephone Number

Name of the Clinic

Name of Physician

Physician's Signature