(translation)

Medical Certificate

	Book No		No		
	Part 1 for the patient who reques	rt 1 for the patient who requests for the medical fitness certificate			
	I, Mr./Mrs./Miss, residing at address				
	ational identification number ————————————————————————————————————				
	would like to request for the medical	yould like to request for the medical fitness certificate. Below is my health history.			
	1. chronic health condition/disease	☐ No ☐ Yes (please speci	fy)		
	2. accident and operation	☐ No ☐ Yes (please speci	fy)		
	3. hospital admission	☐ No ☐ Yes (please speci	fy)		
	4. other important history				
Place of examination				,	
	weight kg, height	•		-	
(2)	I certify that the person is fit to work and free from disability with no symptom of psychosis, dusion, mental retardation, drug addiction, and alcohol use disorder. Also, there is no sign and mptom of the following diseases: I leprosy at the infective stage or the stage with apparent symptoms that may be disgusted by society; tuberculosis at the dangerous period; elephantiasis at the stage with apparent symptoms that may be disgusted by society and other (if any)				
		signature		Physician	

Note:

- (1) must be the physician who owns the medical license;
- (2) describe the patient's fitness. This certificate will be valid for one month since the date of examination;
- (3) this certificate is the result of initial examination.