

# Certificate of Health

(Photo)  
3cm×4cm

Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Phone Number
Passport Number	Address

## Physical examination and Chest X-ray

Height _____ cm	Weight _____ Kg	Blood Pressure / _____ mmHg
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Date of Chest X-ray) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### I. Result:

1. Non-specific ☐
2. Inactive TB ☐
3. Active TB ☐
  - 3-1. Infective) ☐, Non-infective ☐
  - 3-2. Drug-sensitive TB) ☐, MDR TB ☐

### II. Treatment Outcomes - For person who has TB history

1. Under treatment ☐,
2. Cured ☐
3. Completed Treatment ☐
4. Failed ☐
5. Defaulted ☐

The examination was performed as above.

License No.: \_\_\_\_\_ / Name of Physician): \_\_\_\_\_ (signature)

Summary of the examination	
Remarks about examinee's domestic stay	
Additional close examination	Attach doctor's opinion letter, if needed

We hereby certify that the examinee's health status is assessed as above.

**dd. mm. yyyy.**

**0000 Chief of Hospital) (signature)**

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