（別紙様式4）

健　康　診　断　書

<table>
<tr><td colspan="2">フリガナ</td><td></td><td>生年月日</td><td></td></tr>
<tr><td colspan="2">氏　名</td><td></td><td>性　別</td><td></td></tr>
<tr><td colspan="2">現住所</td><td colspan="3">〒

電話</td></tr>
<tr><td colspan="2">身　長</td><td>cm</td><td rowspan="2">既往症</td><td rowspan="2"></td></tr>
<tr><td colspan="2">体　重</td><td>kg</td></tr>
<tr><td rowspan="2">視力</td><td>右</td><td>（　　）</td><td rowspan="4">その他の疾病及び異常</td><td rowspan="4"></td></tr>
<tr><td>左</td><td>（　　）</td></tr>
<tr><td rowspan="2">聴力</td><td>右</td><td></td></tr>
<tr><td>左</td><td></td></tr>
<tr><td rowspan="2">胸部所見</td><td>聴診</td><td></td><td rowspan="2">診断医所見</td><td rowspan="2">健康状態:
□優，　□良，　□可，　□不可

所　　見:</td></tr>
<tr><td>エックス線診断</td><td>撮影年月日　　年　　月　　日
撮影番号　No.

所　　見</td></tr>
</table>

診断の結果，上記のとおり相違ないことを証明します。

年　　月　　日

医療機関所在地　〒

電話

医療機関名

医師　職・氏名　　印

(Attached Form 4)

Certificate of Health

* To be filled out by physician only

<table>
<tr><td colspan="2">Full name in katakana</td><td></td><td>Date of birth</td><td>Yr /Mth /Day</td></tr>
<tr><td colspan="2">Full name</td><td></td><td>Sex</td><td></td></tr>
<tr><td colspan="2">Present Address</td><td colspan="3">Address (including zip code):

Telephone:</td></tr>
<tr><td colspan="2">Height</td><td>cm</td><td rowspan="2">History of past illness</td><td rowspan="2"></td></tr>
<tr><td colspan="2">Weight</td><td>kg</td></tr>
<tr><td rowspan="2">Eyesight</td><td>R</td><td>( )</td><td rowspan="4">Any other illness or abnormality</td><td rowspan="4"></td></tr>
<tr><td>L</td><td>( )</td></tr>
<tr><td rowspan="2">Hearing</td><td>R</td><td></td></tr>
<tr><td>L</td><td></td></tr>
<tr><td rowspan="2">Chest examination</td><td>Stethoscopy</td><td></td><td rowspan="2">Physician's comment</td><td rowspan="2">Condition of health:
☐Excellent ☐Good
☐Fair ☐Poor

Comment:</td></tr>
<tr><td>X-ray diagnosis</td><td>Date taken: Yr /Mth /Day
Film number:

Comment:</td></tr>
</table>

I hereby certify the above statement to be true and correct.

Date: Year /Month /Day

Address of Medical Institution :

Telephone :

Name of Medical Institution :

Physician's Full Name and Position/Title :

Physician's Signature or Seal :