Doshisha Women's College of Liberal Arts
Japanese Studies Program 2025

Certificate of Health

Name of applicant _____, _____, _____ Last First Middle	Sex F	Date of birth _____ Year Month Day	Age
Nationality	Present address		

Height _____ cm

Weight _____ kg

Vision
Without glasses Corrected
Right _____ (_____)
Left _____ (_____)

Color vision

Hearing
Right _____ Left _____

Blood pressure
_____ / _____ mmHg

Chest X-ray (if available) Findings

Urinalysis
Protein Sugar Microscopic
_____ _____ _____

Physical examination

Findings

Previous illness

Remarks (if the applicant is currently taking medicine or undergoing medical treatment, please explain)

General state of physical condition

Excellent Good Fair Poor

Date of report

_____ , _____ , _____
Month Day Year

Signature of physician _____

Name (type or print) _____

Name and address
of medical facility _____