THE 2026 JAPAN EXCHANGE AND TEACHING (JET) PROGRAMME

CERTIFICATE OF HEALTH

To be completed and signed by examining physician. Physician must <u>not</u> be a relative of applicant.

To the Examining Physician (PLEASE READ THOROUGHLY)

You are asked to evaluate the physical and mental health of the applicant for the JET Programme. Participants of the JET Programme will be assigned for a minimum of one year to schools or local government offices in Japan. It is imperative that all participants be able to adjust to dramatic changes in climate, diet, and living conditions. Living and working overseas can also create **emotional** and **physical** stresses in response to the demands of living in a new and different environment. In some cases, mild disorders can become serious due to the stress of life and work in foreign surroundings. It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history.

<u>NOTE</u>: PLEASE FILL IN ALL SECTIONS. ANY MISSING INFORMATION INCLUDING QUESTION 7 MAY HINDER OR PREVENT A CANDIDATE FROM PARTICIPATING.

1.	Applicant's Name:					
	(Last Name)					
	Date of Birth: DD / MM / YYYY	Age: Sex	: □ Male / □ Female / □ Other			
2.	Physical Examination:					
	Height: cm Weight:	kg				
	Blood Pressure:mm/Hg /mm/Hg	Pulse Rate:	_/min □ regular / □ irregular			
Eyesight: (R) (L) (without glasses or contact lenses)						
	(<u>R)</u> (<u>L)</u> (with glasse					
	Colour Blindness: □ normal / □ impaired (if impaired, OK to drive: □)					
	Hearing: □ normal / □ impaired (if imp	aired, OK to drive: □)				
3.	Urinalysis: glucose () protein () occult k	olood () (neg, +2, -, etc.)			
4.	Medical History:					
Please mark any items below that the applicant has ever been diagnosed with. Fill in the name of the disorder and indicate date of diagnosis and/or recovery.						
	If none of the conditions below apply, please chec					
	□ Tuberculosis (MM/YYY	Y) 🗆 Malaria	(MM/YYYY)			
	□ Other Communicable Disease		(MM/YYYY)			
	□ Epilepsy (MM/YYY	Y) □ Renal Disease	(MM/YYYY)			

	☐ Cardiac Diseas	e (MM/)	/YYY) 🗆 Diabetes			
	☐ Drug Allergy			_ (MM / YYYY		
	□ Functional Disorder in Extremities			_ (MM / YYYY		
	☐ Mental Health Disorder (including but not limited to anxiety, depression, eating disorders, OCD, etc.)					
	□ Developmenta	Developmental Disorder (including but not limited to ADD/ADHD, autism, etc.)				
	_	oility (including but not limited to dy	yslexia, dysgraphia, etc.) ational support for reading and writing handwritten/t			
	□ Other (<i>Please s</i> _l		(MM / YYYY)			
5	X-ray Evamination	on or Tuberculosis Test:				
٥.	Please describe the result of the applicant's physical and chest X-ray examination (X-rays taken more than 3 months prior to this certificate are NOT valid).					
	Results of a tuberculosis test must be provided regardless of vaccination history <u>if the X-ray information is not completed</u> below. (<i>Tuberculosis tests taken more than 3 months prior to this certificate are NOT valid</i>).					
	<u>Please Note</u> : As a rule, all applicants who test positive in a PPD test MUST SUBMIT A BLOOD TEST OR TAKE DRUGS TO SUPPRESS TUBERCULOSIS BEFORE COMING TO JAPAN.					
	Date of X-ray:	(DD/MM/YYYY)	Date of Tuberculosis Test: (DD/M	M/YYYY)		
	Lungs: □ norm	al / □ impaired	Results: □ positive / □ negative			
	Cardiomegaly:	□ normal / □ impaired	Results attached:			
	Describe the cor	ndition of applicant's lungs:				
6.	pertinent to the	•	whether requested on this form or not, which nake part in the activities of the JET Programme vtc.).	•		
7.	Health Observation: In view of the applicant's history and the above findings, is it your observation that their health status is adequate to go abroad to participate in the JET Programme? ☐ YES ☐ NO					
	<must a="" be="" by="" d.o.="" m.d.="" or="" physician="" signed="" with=""></must>					
	Date:	Physician's Signa	iture:			
	Physician's Name in Print:					
	Office/Institution	n:				
	TEL:	FAX:	E-mail:			