(Photo)
3cm x 4cm

Certificate of Health

Name :	Sex M F
Date of Birth:	Phone Number
Passport Number :	Address

Physical examination and Chest X-ray

Height : __________cm weight _____________kg Blood Pressure / _________mmHg

Date of Chest X-Ray _________/_________/_________

I.Result

1. Non-spcific ☐
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 Teatment ☐
4. Failed ☐
5. Defauled ☐

The Examination was performed as above.

License No : **/ Name of Physician) :** **(Signature)**

Summary of the examination

Remarks about examinee's domestic stay

Additonal close examination | Attach doctor's oponion letter , if needed

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

dd.mm.yyyy.

0000 Chief of Hospital (Signature)