CERTIFICATE OF HEALTH

(to be filled out by physician)

Name:	Date of Birth:	*Nationality:*
Address:		☐Male ☐Female

1. Height: ..... cm Weight: ..... kg Girth of Chest: ..... cm

   Eyesight:

	(With Glasses)	(Without Glasses)	Hearing:	Color Blindness:
Right:	.....	.....	Right:	☐Normal
Left:	.....	.....	Left:	☐Abnormal

2. History of Illness (if any, indicate with your age of contractions)

   Tuberculosis: ☐ ..... Age Malaria: ☐ ..... Age Rheumatic: ☐ ..... Age

   Epilepsy: ☐ ..... Age Kidney Diseases: ☐ ..... Age Cardiac Diseases: ☐ ..... Age

   Diabetes: ☐ ..... Age Allergy: ☐ ..... Age Other Communicable Diseases: ☐ ..... Age

3. Present Conditions (if any, indicate it)

   ☐Tonsil Nose or Throat ☐Heart or Blood Vessels

   ☐Stomach or Digestive System ☐Genitourinary System

   ☐Brain or Nervous System ☐Blood or Endocrine System

   ☐Lung or Respiratory System ☐Bones, Joints of Locomotors System

   ☐Skin ☐Other Abdominal Organs

4. Chest X-RAY Examination

   ☐Normal

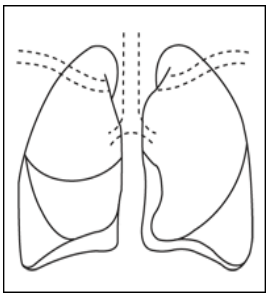
   ☐To be rechecked

   ☐Require medical treatment

   Date of Examination:

   .....

   Describe the condition of applicant's lung



5. I diagnose that the applicant's health and physical conditions are: ☐Excellent ☐Good ☐Fair ☐Poor

6. Any other remarks: .....

I hereby certify the above diagnosed are true

Address of Hospital/Clinic : .....

Name of Physician : .....

Signature & Seal of Physician : .....

Date of Diagnosis: .....