CERTIFICATE OF HEALTH (to be filled out by a physician)

NAME OF APPLICANT(in Roman block capitals)	SEX M. F.	AGE	DATE OF BIRTH
PRESENT ADDRESS			

1. Height _____ cm. Sit-Height _____ cm. Weight _____ kg.
   Blood Pressure : Sys._____ Dia._____ Pulse Rate_____ /m Reg.Irreg .
   Reflexes: Pupil Normal, Abnormal Knee: Normal, Abnormal Others( ): Normal, Abnormal
   Eye-Sight: Left Right Color-Blindness Hearing
   without glasses _____ _____ Yes: ( ) : Normal, Abnormal

2. Anamnesis: please indicate with + or -
   Tuberculosis..... ☐ Malaria.... ☐ Rheumatic Fever....☐ Epilepsy...☐ Kidney Diseases....☐
   Cardiac Diseases.... ☐ Diabetes...☐ Allergy..... .☐ Other Communicable Diseases.....☐

3. Present Conditions: Please indicate with +, if you find any disease or abnormality, or with -, if not.
   Tonsils, Nose or Throat... ☐ Heart or Blood Vessels..... ☐ Lungs or Respiratory System..... .☐
   Stomach or Digestive..... ☐ Genito-Urinary System..... .☐ Other Abdominal Organs..... ☐
   Brain or Nervous System.. . ☐ Blood or Endocrine System... .☐ Bones, Joints or Locomotor System..☐
   Skin..... ☐

4. If you marked + to any of the above 2 and 3, please describe in detail each disease, and if the applicant is physically handicapped, the abnormality or impairment.

5. Describe in full on conditions of applicant´s lungs: (Including the result of Chest X-ray examination and its date)

6. Has the applicant ever suffered from any nervous or mental disorder?

7. In my opinion, the applicant´s health and physical conditions are: (Please check)
   Excellent Good Fair Poor

8. In my opinion, the applicant is physically able to go abroad for study: (Please check) Yes __ No __

NAME & TITLE OF PHYSICIAN (Please print)

_____

ADDRESS

_____

SIGNATURE

_____

DATE

_____

day month year