Medical Certificate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Date of birth | | Sex |
|  | | □ Male  □ Female |
| Present Address |  | | | |
| Diagnosis |  | | | |
| First Consultation Date\* | Year/ Month/ Day | Last Consultation Date\* | Year/ Month/ Day | |
|  |  | |
| Time of Onset | Age of onset / occurrence (0 years in case of congenital)  Approximate age and months : | | | |
| Symptoms\*\* | (Specifically include the progress after onset if possible) | | | |
| Treatment | (If currently receiving treatment) | | | |
| Progress | (Progress of disability / illness) | | | |
| Severity | (Degree of trouble in daily life) | | | |
| Consideration requested when taking examinations | (Issues expected during the examination and considerations to be requested \*\*\*) | | | |

\* Please specify the date of the first and last consultation, which was made at the medical institution which was in charge of issuing this certificate.

\*\* Please attach a copy of the test results, in addition to this medical certificate.

Diagnosis will be made as described above.

Year/　 Month/　 Day

Location of Medical Institution:

Name of Medical Institution:

Phone Number:

Name of Doctor:

Signature: