

# 의사발급 건강진단서/ CERTIFICATE OF HEALTH

Please attach evidential documents which prove that the result of the following examinations is true and correct; otherwise, it is not valid.

## 1. Personal Information

Full Name: \_\_\_\_\_  
 Gender: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Nationality: \_\_\_\_\_

## 2. Physical Examination

Blood Pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ mmHg  
 Vision: Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_ Color Vision \_\_\_\_\_  
 Corrected: Right \_\_\_\_\_/15 Left \_\_\_\_\_/15  
 Dental Evaluation: Good ( ) Fair ( ) Poor ( ) Needs Attention ( )  
 Clinical Evaluation:

Classification	Normal	Abnormal	Classification	Normal	Abnormal
Skin			Heart		
Head & Face			Abdomen		
Eyes			Rectum		
Ears			Genitalia		
Mouth & Throat			Extremities		
Nose & Sinuses			Back & Spine		
Neck			Neurological		
Chest & Lungs			Mental		
			Other		

If Abnormal, please specify: \_\_\_\_\_

## 3. Chest X-ray Examination

. Date taken: \_\_\_\_\_  
 . Findings: \_\_\_\_\_

## 4. Others

Stage	Hepatitis A	MMR
1 <sup>st</sup>	(MM/DD/YY)	(MM/DD/YY)
2 <sup>nd</sup>	(MM/DD/YY)	(MM/DD/YY)

Hemoglobin: \_\_\_\_\_ Gm/dl \_\_\_\_\_  
 Urine: S.G. \_\_\_\_\_ Sugar \_\_\_\_\_ Micro \_\_\_\_\_  
 Hepatitis B: \_\_\_\_\_  
 Stool for Parasite Oval: \_\_\_\_\_  
 Serological Test for Syphilis & AIDS: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 In my opinion his/her health condition is;  
 Excellent ( ) Good ( ) Fair ( ) Poor ( )

This is to certify that the above named applicant has gone through a general medical examination and the findings indicated here are true to the best of my knowledge.

Date		Hospital and Contact Information
M.D		
Signature		