Certificate of Health

Name	Sex □ M □ F	(Photo) 3㎝×4㎝
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-specific □
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 Treatment □
4. Failed □
5. Defaulted □

The examination was performed as above.

License No.: / Name of Physician): (signature)

Summary of the examination	
Remarks about examinee’s domestic stay	
Additional close examination	Attach doctor's opinion letter, if needed

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

dd. mm. yyyy.

0000 Chief of Hospital) (signature)