

CERTIFICATE OF HEALTH (to be filled out by a physician) – page 1

NAME OF APPLICANT (in Roman block capitals)	SEX M · F	AGE	DATE OF BIRTH
DEPARTMENT / MAJOR Applied	Program Intended	Bachelor <input type="checkbox"/> Master's <input type="checkbox"/> Master's+PhD <input type="checkbox"/> PhD <input type="checkbox"/>	
PRESENT ADDRESS			

1. PHYSICAL EXAMINATION :

Height : _____ Cm Weight : _____ Kg
 Blood Pressure : Systolic _____ mmHg Diastolic _____ mmHg Pulse Rate _____ /min (Regular, Irregular)
 Eye-sight : Uncorrected Rt _____ Lt _____ Corrected Rt _____ , Lt _____
 Hearing : Rt _____ dB Lt _____ dB

2. ANAMNESIS : Please indicate, with [+] or [-], whether this person had a history of diseases listed below.

Tuberculosis..... ☐ Malaria..... ☐ Rheumatic Fever..... ☐ Epilepsy..... ☐ Kidney Disease..... ☐
 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 ☐
 GI or Hepatobiliary ☐ Genito-Urinary System... ☐ Venereal Disease..... ☐
 Brain or Nervous System..... ☐ Skin..... ☐ Neurologic system..... ☐
 Blood or Endocrine System.. ☐ Bones, Joints ☐ Mental Illness..... ☐

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

5. LABORATORY FINDINGS :

Blood test	Result	Unit	normal value
Hb		g/dl	
Hct		%	
WBC		k/uL	
GOT		IU/l	
GPT		IU/l	

Serologic test	Result
VDRL(RPR,TPLA)	
AIDS(HIV Ag,Ab)	
HBsAg	
HCV Ab	

6. TB screening test (You can take one of the following tests.)

◆Tuberculin skin Test (Must be taken after March 1st, 2017)

Date tested : _____ Date read : _____ Result : _____ mm

If your Tb skin test result is positive, you must take a Chest X-ray and report the result.

◆ Chest X-ray Examination (Must be taken after March 1st, 2017)

Film No. _____ Date _____ Result: _____

◆ If there is any finding of tuberculosis, please give your comment about the possibility of transmission to others.

7. SUMMARY OF THE EXAMINING PHYSICIAN :

◆ The applicant's health and physical conditions are : (Please check)

Excellent ☐ Good ☐ Fair ☐ Poor ☐

◆ Is the applicant physically able to go abroad for study? (Please check)

Yes ☐ No ☐



CERTIFICATE OF HEALTH (to be filled out by a physician) – page 2

NAME OF APPLICANT (in Roman block capitals)	SEX M · F	AGE	DATE OF BIRTH
--	--------------	-----	---------------

8. Medications

If the applicant is taking any form of medication frequently or regularly, please specify it below.

_____.

_____.

If the applicant has experienced any kind of side effect after taking medicine or injection, please write the name of the medicine that caused it.

_____.

9. Disabilities

Is there any disability that you need special consideration from the university? Yes ☐ No ☐

If 'Yes', please describe it below.

_____.

10. Required Immunizations

Tetanus Original series plus booster every 10 years are required.

Date of last booster : _____

MMR(Measles, Mumps, Rubella) : Two doses of live MMR vaccination record is required.

Date of vaccination

Dose 1 : _____

Dose 2: _____

Varicella One dose of Varicella vaccination record is required.

Date of vaccination : _____

NAME & TITLE OF PHYSICIAN

ADDRESS

SIGNATURE . Date : . . 20

* If you already had a medical examination by a physician inside or outside of Korea within 3 months as of the starting date of semester, it is acceptable to submit the result of that examination instead of this sheet.