Medical Certificate

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  | Year 　/　 Month /　 Day( 　age) | Male/Female |
| Residential 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: Months: |
| Symptoms\*\* | (Specifically include the progress after onset if possible) |
| Test Results |  |
| Treatment | (If currently receiving treatment) |
| CurrentMedication |  |
| Progress | (Progress of disability / illness) |
| Severity | (Degree of trouble in daily life) |
| Expected progress |  |
| Consideration requested at the time of the examination | (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, etc. 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