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) | | | | |
| Current  Medication |  | | | | |
| 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