

2014 JET Programme Application Self-Assessment Medical Report

Interview Location: _____

Please type or handprint clearly.

To the applicant: Please fill out the reference data below. Your application cannot be processed without this form. Successful applicants will be required to submit a JET Programme Certificate of Health, including a chest x-ray, from their physician in April 2014. It is important that you submit correct information regarding your medical history. If you now have or have ever had any physical or mental condition/illness, you must use the attached letter to provide an explanation from your physician stating whether you are fit to participate on the JET Programme and, as such, to live and work overseas. This information will be used to your benefit in deciding your placement as well as in serving as a quick reference should any medical emergencies arise while you are participating on the JET Programme.

Personal Details

NAME:
(as printed in passport)

_____ Last _____ First _____ Middle

DATE OF BIRTH: M / D / Y

1. When and for what reason did you last consult a physician? (Colds, fevers may be omitted. Also visits to OB/GYN facilities or consultations for the requesting of contraception may be omitted.)

- 2a. What diseases, ailments or injuries have you had in the past five years? If any of these resulted in hospitalisation, please give details as to when, why and the duration of the treatment.

- 2b. What is your current status with regard to the condition(s) described in 2a.?

3. Are you currently seeing a physician and/or undergoing treatment? If yes, you must detail below, AND have your doctor fill out the Statement of Physician.

4. Have you ever suffered from any nervous or mental disorders (including, but not limited to anxiety, depression, ADD, ADHD and eating disorders)? If yes, you must detail below AND have your doctor fill out the Statement of Physician. Please note that we may contact your doctor if further information is necessary.

5. Have you ever been treated for any other illness or condition previously undisclosed on this Medical Report? If yes, you must detail below AND have your doctor fill out the Statement of Physician.
6. Do you foresee any physical challenges resulting from the need to go up and down several flights of stairs on a daily basis? If yes, please explain.
7. What allergies do you have, if any? Are you currently undergoing treatment?
8. If you are currently taking, or have taken in the last five years, any prescription medication, *other than oral contraceptives*, please give details including medication's name, purpose and dates taken. Make sure to describe the conditions for which you take any medications listed here in questions 4 and/or 5, above.
9. Are there any foods or substances which, for medical or personal reasons, you do not eat? If so, please give details.
10. Please explain any other health-related issues or disabilities. (ex. Legally blind, hearing impaired, confined to wheelchair, pending medical treatment etc.)
【以下の赤字は、貴地において適当でないと判断する場合には削除ありたい】
Candidates who have tattoos and/or body piercings, please describe the details of the location and the size in this section as well. Please have your doctor complete the Statement of Physician, except tattoos and body piercing.

The answers I have given are correct to the best of my knowledge.

Signature:

Date:

PLEASE RETURN THIS FORM TO:

DEADLINE: