

## Health Certificate for COVID-19

Name (First, Last)	
Gender	
Age	y/o
Date of Birth (dd/mm/yyyy)	
Nationality	
Passport No.	

1) Date of Examination (dd/mm/yyyy)	/ /	
2) Close contact with a person with COVID-19 (probable or confirmed) while they were ill without taking appropriate precautionary measures within the last two weeks.	YES / NO	
3) Clinical symptoms such as cough, shortness of breath, chills, fatigue, muscle pain, headache, sore throat, vomiting, diarrhea, or new loss of taste or smell.	YES / NO	
4) Clinical Manifestation	BT: _____ °C Others:	
5) Testing for COVID-19 (examined on the same day as the examination)		
Sample	Testing for COVID-19	Laboratory result
■ Nasopharyngeal swab	<input type="checkbox"/> Nucleic acid amplification test (Real Time RT-PCR) <input type="checkbox"/> Nucleic acid amplification test (LAMP)	<u>Negative</u> ( Not detected )  *Sample Date (dd/mm/yyyy);

Based on the above information, the person named above is currently healthy and unlikely infected with SARS-CoV-2. Therefore, he or she is fit for flight/work at the current health condition.

Date of Issue (dd/mm/yyyy):

Signature of Physician:

Name of Physician(Printed):

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