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	(Whenever a test is conducted, submit a copy of the documentation of the 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