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## Global Services Center, Korea University

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## Health Certificate

All exchange/visiting students are required to complete this form and submit it within the application period. Those who do not submit the form will not be accepted to Korea University. This form must be completed by a physician/doctor only.

\* Only the examination taken in August to October for spring semester and February to April for fall semester is acceptable. (Date of the examination must be within 2 months from the start of the application period)

Name:	nily name	First name	Middle name	Date of Bi	rth:/
Sex: □ Male	•		Traduct India		1111, 11111
hysical Informatio	<u>n</u>				
Eyesight	□ Normal	□ Impaired (I	Please specify:		
Hearing	□ Normal	□ Impaired (I	Please specify:		
Speech	□ Normal	□ Impaired (I	Please specify:		
Does the applicant	have any allergie	s? (Medication,	Foods, Environmental)	) □ Yes	□ No
If yes, please speci				_ = = =	
Is the applicant cur	rently under med	ical treatment?		□ Yes	□ No
If yes, please speci			physician.		L 110
Is the applicant	montly tolding	madiant:0		_ 17	_ NI -
Is the applicant cur If yes, please speci			physician.	□ Yes	□ No
ii yes, pieuse speei	iy. Ting should be	o completed by a	, prij steram		
Has the small sant a	ff 1 f	af tha falla	:		
Has the applicant e  ☐ Tuberculosis		n any of the folio patitis A/B/C	□ Digestive t	ract disease	□ Others :
□ Diabetes			□ Communic		_ 0
□ Heart disease	□ Psy	ychosis	□ Epilepsy		
If any parts of above	 /e is marked, plea	ase specify. This	should be completed b	y a physician.	□ No remarkable hist
			ke to inform us other (a	any extra physical/	psychological/other
conditions) than the				□ Yes	□ No
If yes, please speci	fy. This should be	e completed by a	physician.		
In view of the appl pursue studies (wit			ings, is it your observa	tion that his/her he  ☐ Yes	alth status is adequate to   □ No
•	• 1		1	□ 1es	□ NO
If no, please specif	y. This should be	completed by a	physician.		
ledical Physician Inf	ormation (Must b	e filled in by a ph	<u>ysician)</u>		
	me in Print:			_	
Physician's Na					
-	nature:				
-	nature:				

Medical Office Official Stamp: \_