2015/7

Graduate School of Medicine
Faculty of Medicine, Osaka University

Certificate of Immunization - Medical Frontier Program

Personal Details of the Student (Please complete in block capitals)

Family Name:	Date of Birth M/D/Y:
Given Name(s):	Sex: Male / Female

	Result of Antibody	Date of Confirmation: M/D/Y	Date of Vaccination: M/D/Y	Result
Hepatitis B surface Antibody blood test				
Varicella(chikenpox)				
Rubella				
Measles				
Mumps				

Result of tuberculin test

Date of result	Result
1st:	
2nd:	

Chest X-ray

Date	Result

I certify that this immunization infromation was transferred from the above-named individual's medical records.

Name of doctor: Date:

Signature:

Facility name:

Official Stamp of health care facility: