Official Use Only:

**MEDICAL DECLARATION**

1. **Present Medical Status**
2. Do you currently use any medicine or have regular medical checkup by a physician for your illness?

No Yes: Name of illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If Yes, please attach your doctor’s letter (preferably, written in English) that describes current status of our illness and agreement to join the project.*

1. Are you pregnant?

No Yes: Months of Pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic to any medication of food?

No Yes: What are you allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate any needs arising from disabilities that might necessitate additional support or facilities.

*Note: Disability does not lead to exclusion of persons with disability from the project. However upon the situation, you may be directly inquired by the Hiroshima University Official in charge for more detailed account of your condition.*

1. **Past Medical History**
2. Have you had any significant or serious illness?

No Yes: Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been in a mental clinic or been treated by a psychiatrist?

No Yes: Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Other medical problems**

If you have any medical problems that are not described above, please indicate below

I certify that I have read the above instructions and answered all questions truthfully and completely to the best of my knowledge.

I understand and accept that medical conditions resulting from an undisclosed pre-existing condition may not be financially compensated by Hiroshima University, Hiroshima Prefectural Government or JICA and may result in the termination of the project.

Subscribed and sworn to before me this \_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature over Printed Name of Applicant