PLEASE PRINT CLEARLY

THE 2027 JAPAN EXCHANGE AND TEACHING (JET) PROGRAMME

STATEMENT OF PHYSICIAN

Explanation of items as indicated by patient (i.e., applicant)

To the Examining Physician

(PLEASE READ THOROUGHLY)

This individual is an applicant to the Japan Exchange and Teaching (JET) Programme and must submit this form concerning their health as indicated on their Self-Report of Medical Condition(s).

The applicant, if chosen, may be offered a year-long contract to work in Japan as a(n):

- **Assistant Language Teacher (ALT)** working for a board of education in foreign language instruction at elementary, junior and senior high schools.
- **Coordinator for International Relations (CIR)** working in a local public office or international exchange organisation handling international projects, exchange programmes, interpretation, etc.

While the JET Programme is an invaluable experience and a time of personal and professional development for participants, it is important for candidates and their physicians to understand that it can be ***emotionally*** and ***physically*** demanding. Participants must adapt to working and living in a new culture and may be placed in rural areas ***with limited access to mental and/or physical healthcare services*** in their native language(s).

If a candidate experiences medical difficulties, physical or psychological, or has only recently recovered from such difficulties, the adjustment demands of the Programme can severely exacerbate those conditions or be cause for relapse. Information provided in this form may be used both to determine eligibility and to assign working places, so accurate information is essential for meeting any special requirements applicants may have.

Name of Medical Condition is to be filled in by the applicant (from Self-Report of Medical Conditions). **Please note that ANY missing medical history may postpone or even PREVENT participation. All other medical details** should be completed by the examining physician, including dates of diagnosis and recovery (if applicable). Physician ***must not*** be a relative of the applicant.

Please write legibly, use generic nomenclature for all listed medicines, and refrain from using doctor's shorthand.

Note: *Japanese law may prohibit importation of certain medications (such as amphetamines and other stimulants). In this case, the applicant may need to use an alternative medication. It may be necessary for the applicant to submit medical import forms for certain medication.*

Applicant's Name:

Filled out by APPLICANT	Filled out by PHYSICIAN				
Name of Medical Condition	**Details and Explanation** (Indicate Date of Diagnosis)	**Prescribed Medicine(s)**	**Amount & Frequency** (If current, leave end date blank)	**Frequency of Check-Ups / Therapy** (Indicate if online)	**Status** (Check one)
	Diagnosed: (DD / MM / YYYY)		**Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Online / Remote** **Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Ongoing** ☐ **Recovered/ In Full Remission as of (MM / YYYY)**
	Diagnosed: (DD / MM / YYYY)		**Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Online / Remote** **Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Ongoing** ☐ **Recovered/ In Full Remission as of (MM / YYYY)**
	Diagnosed: (DD / MM / YYYY)		**Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Online / Remote** **Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Ongoing** ☐ **Recovered/ In Full Remission as of (MM / YYYY)**
	Diagnosed: (DD / MM / YYYY)		**Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Online / Remote** **Start: (MM / YYYY)** **End: (MM / YYYY)**	☐ **Ongoing** ☐ **Recovered/ In Full Remission as of (MM / YYYY)**

To be completed and signed by the examining physician. Please note any additional medical conditions not listed above or special considerations regarding this applicant's participation in the JET Programme:

In view of the applicant's current medicine regimen, medical history, and the above information, **is it your observation that this applicant's health status is adequate to go abroad to participate in the JET Programme for a minimum of one year?**

☐YES ☐NO

Date (DD/MM/YYYY)**:** _____

Physician's Signature: _____

Physician's Name in Print: _____

Office/Institution: _____

Address: _____

TEL: _____ **FAX:** _____ **Email:** _____