



## KOBE UNIVERSITY HOSPITAL

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### Health Certificate

Client Name: \_\_\_\_\_ Date:        /        /  
Hospital ID: \_\_\_\_\_ Gender:        Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Past Medical History: \_\_\_\_\_  
Present Illness: \_\_\_\_\_

#### Assessment

- 1) Laboratory result (Date        /        /        )  
Real-time PCR test for SARS-CoV-2 (Nasal Swab): Negative (Not detected)

#### Comments:

I certify that the result of test above is correct and verifiable.

Physician's name: \_\_\_\_\_

Signature: \_\_\_\_\_

Department of Infectious Diseases,  
Kobe University Hospital



SAMPLE