



KOBE UNIVERSITY HOSPITAL

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Health Certificate

Client Name: _____ Date of issue: / /
Hospital ID: _____ Gender: Age: _____
Date of Birth: _____
Passport number: _____
Past Medical History: _____
Present Illness: _____

Assessment

- 1) Laboratory result (Collection 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