ACTS 아신대학교 ACTS UNIVERSITY

ACTS International Graduate School

Medical Certificate

Patient's Name (Last-First-Middle)		Date of Birth	
Passport No.		Program Applied	M.Div. / Th.M. / Th.M +Ph.D. / Ph.D.
Home Address			
Telephone		E-mail	

This part of the form is to be filled out by a certified physician only. All information should be based on the medical consultation taken within the last 6 months.

Visiting Date (s)			
Diagnosis & Treatment			
Height		FBS (Functioning Blood Sugar)	
Weight		LFT (Liver Function Test)	
Eyesight		CBC (Complete Blood Count)	
Blood Pressure		Respiratory Problem	
Blood Type		Digestive Problem	
Eye Infection		Circulatory Problem	
TB (Tuberculosis)		Mental Illness	
Diabetes		Hypertension	
Cancer		Other	

General medical observation: If there is any health condition of which we should be aware, please use this space or a separate page to describe it.

Name of Physician	Signature & Seal:
Office's Address	
Phone Number	Date: E-mail:

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