Certificate of Testing for COVID-19

Date of issue: _____

Hospital ID: _____

Name: _____ Age: _____ y/o

Sex: _____ Date of birth: _____

Nationality: _____ Passport No: _____

Visiting country: _____ Scheduled date of entry: _____

Address in Japan: _____

Where applicant intends to stay _____

Sample Date and Time:

examined at _____ on _____

Testing for COVID-19 (Sample): RT-PCR (Nasopharyngeal Swab)

Result: _____ Result Date: _____

Inspection equipmen_____

Hakodate Municipal Hospital
1-10-1,Minato,Hakodate,Hokkaido,Japan
Zip:041-8680
Tel:81-138-43-2000Fax:81-138-43-2002

Physician's name Kiyofumi Morishita M.D.

Signature _____

医病SAMPLE