EV	AΜ	ПΠ	

Certificate of Infection Control

実習用 Form1

Name:	Hoa Thi Nguyen	Company/ University:	Hanoi Universi	ty Dental School
Date of birth:	Apr/2/1991	Age:	Sex	Female

		Vaccination*	Date (M/D/Y)
ons	Measles 麻疹	Dose 1	51311992
		Dose 2	4/25/1996
nfecti	Mumps ムンプス	Dose 1	5/3/1992
iral I		Dose 2	4/25/1996
4 Pediatric Viral Infections	Rubella 風疹	Dose 1	51311992
		Dose 2	4/25/1996
	Varicella (Chickenpox) 水痘	Dose 1	5/3/1992
		Dose 2	10/6/1992

* If date of vaccination was copied from MCH handbook or other vaccination record, submission of a copy of the original document is required. (All the documents must be translated in English.)

	Blood test **	Date (M/D/Y)	Result **Submission of a copy o
	HBs Ab	/ /	☐ Positive (10≧mlU/ml) / ☐ Negative
Hepatitis B	Vaccination*	Date (M/D/Y)	
B型肝炎	Dose 1	6/12/1991	* If date of vaccination was copie
NOTE: Please fill EITHER "blood test" or	Dose 2	7/10/1991	handhaals on other seasination n
"vaccination record".	Dose 3	11/27/1991	(All the documents must be tran
	History of info	otion 成选麻	_

te of vaccination was copied from MCH book or other vaccination record, submission copy of the original document is required. the documents must be translated in English.)

*Submission of a copy of test result is required.

	History of infection 感染歴			
		☑ No / ☐ Yes (Month and Year: /)		
Tuberculosis	IGRA test	✓ Date (M/D/Y)	Result	
結核		6/5/2018	□ Positive / ☑ Negative / □ Indeterminate 判定保留	
	Method of testing	☑ QuantiFERON-TB / ☐ T-SPOT.TB		
Influenza インフルエンザ	Vaccination	Date (M/D/Y)	NOTE: Only visitors from Oct. 1st ~ the end of Feb. are required.	
		/ /	✓ Visiting period doesn't include Oct~Feb.	

[•] Please attach a copy of your vaccination record or medical check reports (all the documents must be translated in English). Incase of any abnormal result, you may be asked to take further checks.

This is to certify the information regarding infection control as stated above.

Doctor's Name:	John Smith	Date: 6/26/2018

Signature:

Vietnam National Medical Center Name of Hospital:

12 Phan Phu Doan Street, Hoan Kiem District, Hanoi, Vietnam **Address:**

Okayama University Hospital Ver.1

John Smith

各種ワクチン接種歴,検査結果のコピー (母国語記載の場合は英語訳必要) を添付すること. 異常を認めた場合は精密検査を要求することがあります.

Certificate of Infection Control

実習用 Form1

Name:				Name of company/ University:
Dat	Date of birth (M/D/Y):			Age: Sex:
		Vaccination*	Date (M/D/Y)	
	Measles 麻疹	Dose 1	1 1	
ions		Dose 2	/ /	
4 Pediatric Viral Infections	Mumps ムンプス	Dose 1	/ /	
		Dose 2	1 1	* If date of vaccination was copied from MCH handbook or other vaccination record, submission
	Rubella	Dose 1	/ /	of a copy of the original document is required. (All the documents must be translated in English.)
	風疹 	Dose 2	1 1	
	Varicella (Chickenpox)	Dose 1		
	水痘	Dose 2	/ /	
		Blood test **	Date (M/D/Y)	Result **Submission of a copy of test result is required.
		HBs Ab	1 1	☐ Positive (10≧mlU/ml) / ☐ Negative
F	Hepatitis B	Vaccination *	Date (M/D/Y)	
	B型肝炎 NOTE:	Dose 1	/ /	* If date of vaccination was copied from MCH
	ase fill EITHER 'blood test' or ccination record'.	Dose 2	//	handbook or other vaccination record, submission of a copy of the original document is required. (All the documents must be translated in English.)
vac	contained record .	Dose 3	/ /	(All the documents must be translated in English.)
History		History of infec	tion 感染歴	
			□ No / □ Yes (Month	and Year: /
T	uberculosis 結核	IGRA test **	Date (M/D/Y)	Result **Submittion of a copy of test result is required.
	和核		/ /	□ Positive / □ Negative / □ Indeterminate 判定保留
		Method of testing	□ QuantiFERON-TB /	['] □ T-SPOT.TB
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This is to certify the information regarding infection control as stated above.				
Doc	Doctor's Name:			Date: (M/D/Y)
Sign	ature:			
Nan	ne of Hospital:			

Address: