Certificate of Infection Control

実習用 Form1

Name:

Name of company/ University:

Date of birth (M/D/Y):

Age:

Sex:

		Vaccination*	Date (M/D/Y)	Antibody Titer Test Data/Additional (Booster)Vaccination			
				Testing Method	Test Data（DATE）	Additional (Booster)Vaccination	
4 Pediatric Viral Infections	**Measles** 麻疹	Dose 1	5 / 3 / 1992	EIA	13 (3/3/2025)	Dose 1	4/ 5/ 2025
		Dose 2				Dose 2	/ /
	Mumps ムンプス	Dose 1	5 / 3 / 1992			Dose 1	/ /
		Dose 2	4 / 25 / 1996			Dose 2	/ /
	Rubella 風疹	Dose 1	5 / 3 / 1992	EIA	6 (3/3/2025)	Dose 1	4/ 5/ 2025
		Dose 2				Dose 2	/ /
	Varicella (Chickenpox) 水痘	Dose 1	5 / 3 / 1992			Dose 1	/ /
		Dose 2	10 / 6 / 1992			Dose 2	/ /

Tuberculosis 結核	**Certificate of Diagnosis for Active Tuberculosis (Positive / Negative)**		
	☐ Positive / ☑ Negative Date (M/D/Y)	10 / 6 / 2025	

・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.
・Please be advised that completion of hepatitis B vaccination is strongly recommended.

・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．
・B型型肝炎ウイルスのワクチン接種完了を強く推奨します

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

Doctor's Name: John Smith

Date: 11/26/2025

Signature: John Smith

Name of Hospital: Vietnam National Medical Center

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

Certificate of Infection Control

実習用 Form1

Name: **Name of company/ University:**

Date of birth (M/D/Y): **Age:** **Sex:**

		Vaccination*	Date (M/D/Y)	Testing Method	Test Data（DATE）	Additional (Booster)Vaccination	
4 Pediatric Viral Infections	**Measles** 麻疹	Dose 1	/ /			Dose 1	/ /
		Dose 2	/ /		(/ /)	Dose 2	/ /
	Mumps ムンプス	Dose 1	/ /			Dose 1	/ /
		Dose 2	/ /		(/ /)	Dose 2	/ /
	Rubella 風疹	Dose 1	/ /			Dose 1	/ /
		Dose 2	/ /		(/ /)	Dose 2	/ /
	Varicella (Chickenpox) 水痘	Dose 1	/ /			Dose 1	/ /
		Dose 2	/ /		(/ /)	Dose 2	/ /

Antibody Titer Test Data/Additional (Booster)Vaccination

Tuberculosis 結核	**Certificate of Diagnosis for Active Tuberculosis (Positive / Negative)**	
		☐ Positive / ☐ Negative Date (M/D/Y)(/ /)

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Doctor's Name: **Date:** **(M/D/Y)**

Signature:

Name of Hospital:

Address: