

FUKUYAMA CITY HOSPITAL

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Health Certificate for COVID-19

Name (First, Last)	
Gender	
Age	y/o
Date of Birth (dd/mm/yyyy)	
Nationality	
Passport No.	

This is to certify the following results which have been confirmed by testing for COVID-19 conducted with the sample taken from the above-mentioned person.

1) Testing Item	Nucleic acid amplification test
2) Sample	Nasopharyngeal Swab
3) Testing Method for COVID-19	real time RT-PCR
4) Result	Laboratory result Negative (Not detected)
5) Specimen Collection Date and Time	Date(dd/mm/yyyy) Time ____/____/____ ____
6) Test Result Date and Time	Date(dd/mm/yyyy) Time ____/____/____ ____
7) Date of Issue	Date(dd/mm/yyyy) Time ____/____/____ ____

Signature of Physician :

Name of Physician(Printed) :