THE MEDICAL EXAMINATION FORM

<table>
<tr><td>Name-Surname</td><td>Sex</td><td>Date of Birth/Place of Birth</td><td>Photo
(Stamped Official Stamp)</td></tr>
<tr><td></td><td>☐ Male
☐ Female</td><td></td><td rowspan="3"></td></tr>
<tr><td>E-mail address</td><td colspan="2"></td></tr>
<tr><td>Nationality</td><td colspan="2"></td></tr>
<tr><td colspan="4">Do you have any of the following disease or disorders endangering the public order and security? (Each item must be answered “Yes” or “No”)</td></tr>
<tr><td colspan="2">Toxicomania: ☐ No ☐ Yes
Mental Confusion: ☐ No ☐ Yes
Psychosis: ☐ No ☐ Yes
Paranoid Psychosis: ☐ No ☐ Yes
Hallucinatory Psychosis: ☐ No ☐ Yes</td><td colspan="2">Manic Psychosis: ☐ No ☐ Yes
HIV (AIDS): ☐ No ☐ Yes
Yellow Fewer: ☐ No ☐ Yes
Malaria: ☐ No ☐ Yes</td></tr>
<tr><td>Height cm</td><td>Weight kg</td><td colspan="2">Blood Pressure mmHg</td></tr>
<tr><td>Development</td><td>Nourishment</td><td colspan="2">Nervous System</td></tr>
<tr><td>L
Vision R</td><td>L
Corrected Vision R</td><td colspan="2">Color Sense</td></tr>
<tr><td>Neck</td><td>Skin</td><td colspan="2">Lymph nodes</td></tr>
<tr><td>Heart</td><td>Lungs</td><td colspan="2">Abdomen</td></tr>
<tr><td>Spine</td><td>Extremities</td><td colspan="2">Other
abnormal findings</td></tr>
<tr><td>Chest X-ray exam
(Attached chest X-ray report)</td><td></td><td>ECG</td><td></td></tr>
<tr><td colspan="2">Laboratory exam
(Attached test report of AIDS, Syphilis etc.)</td><td colspan="2"></td></tr>
<tr><td colspan="4">Suggestion: Official Stamp:

Signature of physician: Date:

I hereby declare that, this person has no contagious and chronic (that requires continuous treatment) disease.</td></tr>
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