Cautions in drawing up a medical certificate

(診断書作成にあたっての注意事項)

No.	Item(項目名)	Instructions (注意事項)
2． ⅲ.	Complications of Requiring hospitalization treatment	If there were coexisting diseases and/or complications requiring hospitalization treatment, please write the name of the disease(s), the date of onset,and the date of diagnosis.
	入院加療が必要な併存疾患･合併症	入院加療の必要があった併存疾患・合併症があれば、傷病名、傷病発生年月日、診断年月日を記入ください。
2． ⅳ.	In case of malignant neoplasm Including carcinoma in situ, non-invasive carcinoma, and CIN3	If there are no histopathological diagnoses, please write other bases for diagnosis.
	がんの場合、上皮内がん、非浸潤がん、CIN3 を含みます	病理組織診断がない場合はその他の診断根拠を記入ください。
3． ⅲ.	Outpatient	Circle the dates of hospital visits aimed at receiving pre-hospitalization and post-discharge treatments. Make sure to write the total number of days for each month.
	通院	入院前・退院後の治療を目的とする通院日に〇を付けてください。各月の合計日数は必ず記入ください。
4．	Special professional Intervention	If a vascular catheter test was performed on the heart, please write the laboratory findings.
	特定検査	心臓血管カテーテル検査の場合は、検査所見を記入ください。
5．	Operation	If vascular catheter surgery was performed on the blood vessels of the limbs, and if multiple sites were operated on, please write the site(s) operated on as your comments on the surgery.
	手術	血管カテーテル手術で四肢の血管に対する手術の場合や、複数部位にわたる場合は、施行部位を手術に関するコメントとして記入ください。
6．	Radiotherapy Quantity in total Gray GBq	If radiotherapy and/or cancer thermotherapy had been performed, make sure to write the method of anesthesia and the date the treatment was performed(duration), etc.
	放射線照射 総線量 グレイ ギガベクレル	放射線治療、がんに対する温熱治療を実施された場合は、麻酔法・治療実施日(期間)等について必ず記入ください。

To Asahi Mutual Life Insurance Company

English only：Please type or write in block letters.

MEDICAL CERTIFICATE(Attending physician's statement)

1. Patient's Name(患者氏名) (SURNAME:姓) /(FIRSTNAME:名)	Sex(性別) ☐Male(男) ☐Female(女)	Patient's Date of Birth(生年月日) / / Month Day Year

2. Name of Disease and / or Injury(傷病名)

	Onset Date of Disease/Injury (傷病発生)	Diagnosis Date of Disease (診断日)
i. Name of Disease/Injury for Hospitalization(Operation) (傷病名)	/ / Month Day Year	/ / Month Day Year
ii. Etiology(原因)	/ / Month Day Year	/ / Month Day Year
iii. Complications of *Requiring* Hospitalization treatment(合併症)	/ / Month Day Year	/ / Month Day Year

iv. In case of malignant neoplasm *Including* carcinoma in situ, non-invasive carcinoma, and CIN3 (がんの場合)

Histopathological diagnosis(病理組織学的診断)			
Date of diagnosis(診断日)	/ / Month Day Year	TNM classification(pTNM)	

3. Period of Medical Treatment(治療期間)

i. Date of Initial consultation (初診日) / / Month Day Year

ii. Hospitalization (入院)

The 1st.	from / / Month Day Year to / / Month Day Year	☐ Discharged(退院) ☐ Inpatient(入院中)
The 2nd.	from / / to / /	☐ Discharged ☐ Inpatient
The 3rd.	from / / to / /	☐ Discharged ☐ Inpatient

iii. Outpatient (通院):Please circle day(s)

	Days	Total
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)

4. Special professional Intervention(特定検査) :Check the box

Type	☐①Cerebral angiography(脳血管ｶﾃｰﾃﾙ検査) ☐②Cardiac catheterization(心臓ｶﾃｰﾃﾙ検査) ☐③Laparoscopy(腹腔鏡検査) ☐④Thoracoscopy(胸腔鏡検査) ☐⑤Mediastinoscopy(縦隔鏡検査)
Name of Intervention(検査名)	Date of Intervention(検査日) / / Month Day Year
Type of anesthesia	☐①General anesthesia(全身麻酔) ☐②Other anesthesia(その他の麻酔) ☐③None(麻酔なし)

5. Operation(including surgical Intervention) (手術) :Check the box

Type	☐①Craniotomy(開頭術) ☐②Burr hole opening(穿頭術) ☐③Thoracotomy・Thoracoscopic surgery(開胸・胸腔鏡下手術) ☐④Laparotomy・Laparoscopic surgery(開腹・腹腔鏡下手術) ☐⑤Endoscopic surgery(ﾌｧｲﾊﾞｰｽｺｰﾌﾟ手術) ☐⑥Intravascular surgery(血管ｶﾃｰﾃﾙ手術) ☐⑦Others( )
Details	☐ In case of skin grafting 25㎠ or above(植皮面積25㎠以上である)
Name of Operation(手術名)	Date of Operation(手術日) / / Month Day Year
Type of anesthesia	☐①General anesthesia(全身麻酔) ☐②Other anesthesia(その他の麻酔) ☐③None(麻酔なし)

6. Radiotherapy (放射線照射)

Region (部位)	Quantity in total (総線量) Gray	GBq
Period(期間)	from / / Month Day Year to / / Month Day Year	
Type of anesthesia	☐①General anesthesia(全身麻酔) ☐②Other anesthesia(その他の麻酔) ☐③None(麻酔なし)	

I hereby certify that all the information given is correct.

Name of hospital ....

Date: / / Month Day Year

Address of hospital ....

Country ....

Signature of doctor ....