APPLICATION FOR ADMISSION

ADB-JSP MASTER PROGRAM, SCHOOL OF INTERNATIONAL HEALTH, THE UNIVERSITY OF TOKYO

Please complete the form in block letters or type, so that your information can be easily read.

1. Name: _____ _____ _____ (Male/Female)

   (Family name) (First name) (Middle name)

2. Date of birth: _____

3. Nationality: _____

4. Marital status: (Single/Married)

5. Family members residing in Japan: (Yes/No) (relationship)

6. Current student or employment status (with name of university or employer):

   _____

7. Current mailing address:

   _____

   Telephone number:_____ Fax number:_____

   E-mail: _____

   Permanent home address:

   _____

8. Academic record(s):

   (a) Bachelor: (Degree) _____

   (Major) _____

   (Dates) From to _____ (Day/Month/Year)
   (Day/Month/Year)

   (Name and address of institution) _____

   _____

(b) If you have received other Bachelor, Masters or Doctoral degrees, please indicate the details below.

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9. Total period of education (from elementary school to last institution of education)

Years

10. Please indicate here one of the Departments in School of International Health, the University of Tokyo, in which you wish to undertake your research. (Please consult with GUIDE TO SCHOOL OF INTERNATIONAL HEALTH, THE UNIVERSITY OF TOKYO.)

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11. Please describe your research proposal during the course when you are admitted to the ADB-JSP Program, using less than 2 pages of sheets attached.

Explain the title and contents of your research proposal

Research title:

Contents:

(continued)

Form #2

SELF-EVALUATION OF ACADEMIC LEVEL

ADB-JSP PROGRAM IN SCHOOL OF INTERNATIONAL HEALTH THE UNIVERSITY OF TOKYO

Name of applicant:_____

1. English language proficiency (Mark one of the following five categories):

   Equivalent to native English speaker Excellent
   Good Usual
   Poor

2. Most recent score of TOEFL or IELTS.

   TOEFL: (score) _____ (date) _____

   IELTS: (score)_____ (date) _____

3. State your scholastic abilities as clear as possible, and if you have received awards or scholarships, please specify them.

Form #3

CERTIFICATE OF HEALTH (to be completed by examining physician)

Please print or type in English.

Name: (Mr./ Ms.)

Date of birth:

1. Physical examination

   Height: Body weight: Blood pressure: /

   Pulse: (regular/ irregular)

   Visual acuity (eyesight): (R) (L)
   (with glasses or contact lenses): (R) (L)

2. Describe the results of X-ray examinations of applicant's chest (X-rays taken more than 6 months prior to the certification are NOT valid).
   Date:
   Film No.:
   Cardiomegaly: (+ ± -)

3. Past history: please indicate with [+] for YES or[-]for NO.

Tuberculosis:	Kidney disease:
Malaria:	Cardiac disease:
Rheumatic fever:	Diabetes:
Epilepsy:	Allergy:

Other communicable diseases (if YES, specify):

4. Please describe your impressions of the patient.

(a) Is the applicant emotionally stable?

(b) Does the applicant appear to have a normal behavior pattern?

Physician's name in print:

Office/institution (Name and address):

Date: Signature: