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9.Period of occupational disability		From (dd/mm/yyyy) / /	To (dd/mm/yyyy) / /
10.In case of acute myocardial infarction		Whether limitation of work (excluding the one such as housework / desk work) has continued more than 60 days from the first visit. ☐ Yes ☐ No	
11. In case of stroke	Whether limitation of work (excluding the one such as house work / desk work) has continued more than 60 days from the first visit. ☐ Yes ☐ No		
	Whether sequelae of central nervous system has continued more than 60 days from the first visit. ☐ Yes ☐ No If Yes, please describe details:		
12. In case of neoplasm			
(i)Final diagnosis	/ /	(dd/mm/yyyy)	
(ii)Examination for Diagnosis			
Examination	Date of final result	Result	
Histology	/ / (dd/mm/yyyy)		
Cytology	/ / (dd/mm/yyyy)		
Other examination	/ / (dd/mm/yyyy)		
TNM classification, Invasion depth, Condition			
T() N() M() Stage()	In case of colon cancer, ☐ m ☐ sm or deeper	Present condition ☐ cured ☐ remission ☐ therapy continued	
(iii)Has this patient ever diagnosed malignant or non-invasive carcinoma (including carcinoma in situ) ☐ No ☐ Yes Diagnosis: _____ Date of Diagnosis / / (dd/ mm/ yyyy)			
(iv)Antineoplastic ☐ not administered ☐ will be administered ☐ being administered	Name of Antineoplastic _____ Date of administration (mm/yyyy) _____ / _____ , _____ / _____ , _____ / _____ , _____ / _____ , _____ / _____ , _____ / _____		
13.Outpatient visit dates for treatment			
Month/Year	Please circle the dates.		
/	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		
/	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		
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/	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		
I hereby certify that the above-stated facts are true and correct.			
Country: Address of hospital/clinic: Name of hospital/clinic: Department:		Date of Certification / / (dd/mm/yyyy)	
Telephone number:		Signature	
Name of Doctor			