Certificate of Testing for COVID-19

Date of issue: _____

Hospital ID: _____

Name: _____ Age: _____ y/o

Sex: _____ Date of birth: _____

Nationality: _____ Passport No: _____

Visiting country: _____ Scheduled date of entry: _____

Address in Japan: _____

Where applicant intends to stay in the visiting country(address): _____

Sample Date and Time:

examined at _____ on _____

Testing for COVID-19 (Sample): RT−PCR (Nasopharyngeal Swab)

Result: **Negative** Result Date: _____

Hakodate Municipal Hospital
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Zip:041-8680
Tel:81-138-43-2000 Fax:81-138-43-2002

Physician's name Kiyofumi Morishita M.D.

Signature _____