Veterans General Hospital Hospital
Certificate of Pulmonary Tuberculosis and Hepatitis B for a Foreign Medical Student

Last name	**First name**	**Nationality**

Gender ☐Male ☐Female	**Date of Birth** (mm/ dd/ yyyy):

ID or Passport Number	**Present Address**

A. Certificate of Pulmonary Tuberculosis (To be completed by physician)

I have examined the x-ray (should be taken within the recent 3 months) of____
(name of trainee), and find the individual appears to be free of communicable tuberculosis.

Name & title of physician: ____

Address: ____

Signature: ______________________________________

Date (mm-dd-yyyy): _______________________________

B. Declaration of Hepatitis B status

HBsAg:+，HBsAb:-	
HBsAg:-，HBsAb:+	
HBsAg:-，HBsAb:-，I understand the risk of being infected with Hepatitis B and will consider taking proper actions, including take vaccine, to protect myself.	

Applicant's Signature: ____________________________________

Date (mm-dd-yyyy) ：_____________________________________