MEDICAL CERTIFICATE

Date: __ / __ / ____

Doctor's Name: _____
Doctor's Medical License ID: _____

Name of Doctor's Office: _____
Address: _____
City, State, Zip Code: _____
Phone Number: _____

I, the undersigned, Mr.,Ms. /본인 _____ *은*
doctor's name / 검사자의 성명

Doctor, practicing in _____ *에서 일하는 의사로서*
city /도시

Certifies having examined on _____ *at* _____ *에*
date / 날짜 *time/시간*

Mr.,Ms. _____ *을 진단했습니다*
patient's name / 환자의 성명

Born on _____
YYYY-MM-DD / 생년월일

At the end of the examination, the patient has (YES/네) / does not have (NO/아니오) the following symptoms:
진단 결과, 환자는 아래 증상이 있습니다 / 없습니다:

	YES/네	NO/아니오
- FEVER / *발열* ……..	☐ YES	☐ NO
- COUGH / *기침* ……..	☐ YES	☐ NO
- JAUNDICE / *황달* ……...	☐ YES	☐ NO
- CHILLS / *오한* ……..	☐ YES	☐ NO
- SHORTNESS OF BREATH / *호흡곤란* ……...	☐ YES	☐ NO
- LOSS OF CONSCIOUSNESS / *의식저하* ……..	☐ YES	☐ NO
- HEADACHE / *두통* ……..	☐ YES	☐ NO

- **VOMITING** / *구토* ……. ☐ YES ☐ NO

- **BLOODY MUCUS** / *점막 지속 출혈* ……. ☐ YES ☐ NO
**Eyes, nose, mouth, etc. / * 눈, 코, 입 등*

- **SORE THROAT** / *인후통* …….. ☐ YES ☐ NO

- **ABDOMINAL PAIN OR DIARRHEA** / *복통 또는 설사* ……. ☐ YES ☐ NO

- **RUNNY NOSE** / *콧물* ……... ☐ YES ☐ NO

- **RASH** / *발진* ……..... ☐ YES ☐ NO

- **MUSCLE PAIN** / *근육통* …….. ☐ YES ☐ NO

- **PNEUMONIA** / *폐렴* ……..... ☐ YES ☐ NO

- **PULMONARY SYMPTOMS** / *폐렴* ……... ☐ YES ☐ NO

- **LOSS OF TASTE AND/OR SMELL** / *후각.미각 상실* …….. ☐ YES ☐ NO

- **OTHER SYMPTOMS** / *그 밖의 증상 :*
(_____) …….. ☐ YES ☐ NO

Additional Comments:

_____

_____

_____

Signature: _____ **Date:** __ / __ / ____
검사자의 서명 날짜

Stamp of the medical examiner:
검사자의 직인