Appendix 2

Forms of Application and Questionnaire for Medical Institution

Contents

(Face side)

Date of submission: ____/____/____ (DD/MM/YY)

Application Form for

1. Health Management Allowance
2. Health Allowance
3. Health Allowance (for Revision of the amount)
4. Special Medical Care Allowance
5. Special Allowance
6. Atomic Bomb Microcephaly Allowance

To Governor (or Mayor) of _____

Name	(Seal)	Date of birth / / (DD/MM/YY)		Sex male / female
Residence as printed on certificate		Last issued A-bomb survivor's certificate	(Name of prefecture or city) Please state whether you are:	
			A-bomb survivor's certificate number	
Present residence	Address Telephone number			
In receipt of Health Management Allowance	yes / no	In receipt of Health Allowance		yes / no
In receipt of Special Medical Care Allowance	yes / no	In receipt of Special Allowance		yes / no
In receipt of Atomic bomb Microcephaly Allowance	yes / no			

Health Management Allowance	About disease accompanied by disorder as described in clause 1 of Article 27 of the Law	Name of disorder	1 Hematopoietic dysfunction 2 Liver dysfunction 3 Dysfunction of cellular proliferation 4 Endocrine dysfunction 5 Cerebrovascular disorder 6 Cardiovascular dysfunction 7 Renal dysfunction 8 Visual dysfunction due to lens opacity 9 Resoiratory dysfunction 10 Motor dysfunction 11 Digestive tract dysfunction due to ulceration
		Name of disease (A)	
	Attached document	Medical Certificate for disease entered above (A)	
Health Allowance	A-bomb survivor's certificate number		
	Item of clause 3 of Article 28 of the law that applies to you (if any)	1 Physically handicapped person	
		2 Person aged over 70 years old living alone with no spouse, children and grandchildren	
	Attached papers	1. Medical certificate for physical disorder if marked 1 above 2. Following certificates if marked 2 above (1) Certificate issued by official agency in your country to certify that you have no spouse, child or grandchildren (2) Certificate to certify that you live alone 3. Certificate to certify that you were within 2km from the center of the explosion (If you don't have such a certificate please attach a statement that you were within 2km from the center of the explosion.)	

(Reverse side)

<table>
<tr><td rowspan="6">Special Medical Care Allowance/ Special Allowanve/ Atomic Bomb Microcephaly Allowance</td><td colspan="3">Authorized by the 1st clause of Article11 of the law?</td><td>yes / no</td></tr>
<tr><td rowspan="2">Name of injury or disease, number and date of authorization about the 1st clause of Article11 of the law</td><td>Name of injury or disease (B)</td><td>Number of authorization</td><td>Date of authorization</td></tr>
<tr><td></td><td></td><td>/ / (DD/MM/YY)</td></tr>
<tr><td colspan="2">Status of injury or disease above (B)</td><td colspan="2">as attached medical certificate</td></tr>
<tr><td colspan="2">Attached papers</td><td colspan="2">1. Special Medical Care Allowanc
Medical certificate for injury or disease entered above (B)

2. A-bomb Microcephaly Allowance Medical certificate
Note: a medical certificate is unnecessary when the injury or disease entered in B above is microcephaly or short distance early prenatal A-bomb radiation syndrome.</td></tr>
<tr><td colspan="5">Remarks:</td></tr>
</table>

Notes

1. Regarding “Name” and “Residence as printed on certificate”, please write in the same language as used in the A-bomb survivor’s certificate.
2. Regarding “Name of disease” and “Name of injury or disease”, please write in Japanese or English.
3. Regarding Name, please fill in name and seal, or signature.

○ Please do not write below.

(For office use)

Date of receipt	/ / (DD/MM/YY)
Name of office	Embassy/ Consulate-General of Japan in
Name of person in charge	

(Sample)

In Applying for Health Management Allowance

(Face side)

Application Form for

Date of submission: _____/_____/_____(DD/MM/YY)

(1) Health Management Allowance
2. Health Allowance
3. Health Allowance (for Revision of the amount)
4. Special Medical Care Allowance
5. Special Allowance
6. Atomic Bomb Microcephaly Allowance

Circle "1. Health Management Allowance".

To Governor (or Mayor) of _____

Enter the name of municipal/prefectural government which issued your A-bomb survivor's certificate in Japanese or English.

Name	Taro Kousei (Seal)	Date of birth: DD/MM/YY		Sex: male / female
Residence as printed on certificate)	xx-shi, xx-cho, x-chome, xxxx	Last issued A-bomb survivor's certificate	(Name of prefecture or city) Please state whether you are:	
			A-bomb survivor's certificate number	1 2 3 4 5 6 7

- Referring to your A-bomb survivor's certificate, fill in each blank in the same language.
- You can sign your name if you do not have a personal seal.

Present residence	Address 1234 Kousei Street, San Francisco, CA 94000, USA Telephone number 012 –345- 6789

Enter your current address as shown on your identification papers.

In receipt of Health Management Allowance	yes / no	In receipt of Health Allowance	yes / no
In receipt of Special Medical Care Allowance	yes / no	In receipt of Special Allowance	yes / no
In receipt of Atomic bomb Microcephaly Allowance	yes / no		

If you receive any Allowance at present, encircle "have" for the applicable item. If you do not receive any Allowance, circle "do not have".

Health Management Allowance	About disease accompanied by disorder as described in clause 1 of Article 27 of the Law	Name of disorder	1 Hematopoietic dysfunction 2 Liver dysfunction (3) Dysfunction of cellular proliferation 4 -Endocrine dysfunction 5 Cerebrovascular disorder 6 Cardiovascular dysfunction 7 Renal dysfunction 8 Visual dysfunction due to lens opacity 9 Resoiratory dysfunction 10 Motor dysfunction 11 Digestive tract dysfunction due to ulceration
		Name of disease (A)	Lung cancer
	Attached document	Medical Certificate for disease entered above (A)	

- Refer to the type of disorder on your Medical Certificate and circle the number of the applicable disorder.
- Refer to the name of disease on your Medical Certificate and enter its name in either Japanese or English.
- Attach the relevant Medical Certificate.

Health Allowance	A-bomb survivor's certificate number	
	Item of clause 3 of Article 28 of the law that applies to you (if any)	1 Physically handicapped person
		2 Person aged over 70 years old living alone with no spouse, children and grandchildren
	Attached papers	1. Medical certificate for physical disorder if marked 1 above 2. Following certificates if marked 2 above (1) Certificate issued by official agency in your country to certify that you have no spouse, child or grandchildren (2) Certificate to certify that you live alone 3. Certificate to certify that you were within 2km from the center of the explosion (If you don't have such a certificate please attach a statement that you were within 2km from the center of the explosion.)

(Reverse side)

<table>
<tr><td rowspan="5">Special Medical Care Allowance/ Special Allowanve/ Atomic Bomb Microcephaly Allowance</td><td colspan="4">Authorized by the 1st clause of Article11 of the law?</td><td>yes / no</td></tr>
<tr><td rowspan="2">Name of injury or disease, number and date of authorization about the 1st clause of Article11 of the law</td><td colspan="2">Name of injury or disease (B)</td><td>Number of authorization</td><td>Date of authorization</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="2">Status of injury or disease above (B)</td><td colspan="3">as attached medical certificate</td></tr>
<tr><td colspan="2">Attached papers</td><td colspan="3">1. Special Medical Care Allowanc
Medical certificate for injury or disease entered above (B)

2. A-bomb Microcephaly Allowance Medical certificate
Note: a medical certificate is unnecessary when the injury or disease entered in B above is microcephaly or short distance early prenatal A-bomb radiation syndrome.</td></tr>
<tr><td colspan="6">Remarks:</td></tr>
</table>

Notes

1. Regarding “Name” and “Residence as printed on certificate”, please write in the same language as used in the A-bomb survivor’s certificate.
2. Regarding “Name of disease” and “Name of injury or disease”, please write in Japanese or English.
3. Regarding Name, please fill in name and seal, or signature.

○ Please do not write below.

(For office use)

Date of receipt	/ / (DD/MM/YY)
Name of office	Embassy/ Consulate-General of Japan in
Name of person in charge	

Application Form for Funeral Assistance

To Governor (or Mayor) of_____

Date of submission: ____/____/____(DD/MM/YY)

<table>
<tr><td colspan="2">Name of applicant</td><td>(Seal)</td><td>Relationship to deceased A-bomb survivor</td><td></td></tr>
<tr><td colspan="2">Address of applicant</td><td colspan="3">Address

Telephone number</td></tr>
<tr><td colspan="2">Date of funeral</td><td colspan="3">/ / (DD/MM/YY)</td></tr>
<tr><td rowspan="8">Regarding dead A-bomb survivor</td><td>Name</td><td></td><td>Date of birth</td><td>male/ female</td></tr>
<tr><td>Address at time of death</td><td colspan="3"></td></tr>
<tr><td>Last issued A-bomb survivor's certificate</td><td>(Name of prefecture or city)</td><td colspan="3">A-bomb survivor's certificate number
       </td></tr>
<tr><td>Date of death</td><td colspan="3"></td></tr>
<tr><td>Place of death</td><td colspan="3"></td></tr>
<tr><td>Cause of death</td><td colspan="3"></td></tr>
<tr><td>Bereaved family members</td><td colspan="3">yes
1 Spouse 2 Child 3 Parent
4 Grandchild 5 Grandparent 6 Brother or Sister
none
unknown</td></tr>
</table>

Notes

1. Regarding “Name” and “Last issued A-bomb survivor's certificate”, please write in the same language as used in the A-bomb survivor’s certificate.
2. Regarding “Place of death” and “Cause of death”, please write in Japanese or English.
3. Regarding Name, please fill in name and seal, or signature.

Attached papers

Please attach document certifying the fact and cause of death..

○ Please do not write below.

(For office use)

Date of receipt	/ / (DD/MM/YY)
Name of office	Embassy/ Consulate-General of Japan in
Name of person in charge	

(Sample)

Applying for Funeral Assistance

Application Form for Funeral Assistance

To Governor (or Mayor) of_____

Enter the name of municipal/prefectural government which issued your A-bomb survivor's certificate in Japanese or English.

Date of submission: _____/ ___/ ___(DD/MM/YY)

Name of applicant		Hanako Kousei (Seal)	Relationship to deceased A-bomb survivor	Wife	Enter your name and address as shown on your identification papers.
Address of applicant		Address 1234 Kousei Street, San Francisco, CA 94000, USA Telephone number 012-345-6789			
Date of funeral		DD/MM/YY			
Regarding dead A-bomb survivor	Name	Taro Kousei	Date of birth DD/MM/YY	male/ female	Referring to your A-bomb survivor's certificate, fill in each blank in the same language.
	Address at time of death	1234 Kousei Street, San Francisco, CA94000, USA			Enter address at time of death.
	Last issued A-bomb survivor's certificate	(Name of prefecture or city) Prefecture xxx City	A-bomb survivor's certificate number 1 2 3 4 5 6 7		Referring to your A-bomb survivor's certificate, fill in each blank in the same language.
	Date of death	DD/MM/YY			Referring to any document explaining the cause of death, fill in each blank in Japanese or English.
	Place of death	Kousei Hospital			
	Cause of death	Lung cancer			
	Bereaved family members	Yes 1 Spouse 2 Child 3 Parent 4 Grandchild 5 Grandparent 6 Brother or Sister None unknown			Circle the applicable items.

Notes

1. Regarding “Name” and “Last issued A-bomb survivor’s certificate”, please write in the same language as used in the A-bomb survivor’s certificate.
2. Regarding “Place of death” and “Cause of death”, please write in Japanese or English.
3. Regarding Name, please fill in name and seal, or signature.

Attached papers

Please attach document certifying the fact and cause of death.

○ Please do not write below.

(For office use)

Date of receipt	/ / (DD/MM/YY)
Name of office	Embassy/ Consulate-General of Japan in
Name of person in charge	

Medical Certificate for Health Management Allowance

Name		Date of birth / / (DD/MM/YY)	Male/ female
Residence			
*1 Disorders (Circle the applicable items)	1 Hematopoietic dysfunction 2 Liver dysfunction 3 Dysfunction of cellular proliferation 4 Endocrine dysfunction	5 Cerebrovascular disorder 6 Cardiovascular dysfunction 7 Renal dysfunction 8 Visual dysfunction due to lens opacity	9 Respiratory dysfunction 10 Motor dysfunction 11 Digestive tract dysfunction due to ulceration
*2 Name of disease accompanied by the disorder indicated above			
Describe your views for cases where it is clear that the disease was not the result of A-bomb radiation, including cases where the disease is attributable to infectious disease, parasite infection, birth defect, poisoning and other causes, or to industrial accident and unintentional injury.			
Comment on whether or not symptoms of the diseases shown in Item *2 above are persistent	1. Persistent 2. Not persistent (Expected duration of treatment for the said *2 disease: year(s) and month(s))		

*3 Present status	Physical test (Clinical findings)	Cardiac sound				
		Lung field				
		Abdomen				
		Locomotorium				
	Clinicopathologic test	Hematological test (Date:)	(Peripheral blood)			
			Hemoglobin content g/dL %	Erythrocyte count $\times10^4$/mm^3	Rericulocyte count ‰	Leukocyte count /mm^3
			Granulocyte count /mm^3	Pathological cell %	Platelet count $\times10^4$/mm^3	
			Serum iron μg/dL		Serum calcium mg/dL	
			(Bone marrow)			
			Nuclear cell count $\times10^4$/mm^3	Megakaryocyte count /mm^3	Lymphocyte %	E/M
		Liver function test (Date:)	TP g/dL	GOT	ALP	
			A/G	GPT	ZTT (Kunkel unit)	
			Bilirubin mg/dL	LDH	ICG (15-min.measurement) %	
		Urinalysis (Date:)	Opacity		Protenuria 1 positive 2 negative	
			Glucose	1 positive 2 negative	Urobilinogen 1 increase 2 normal 3 decrease	
		Stool occult blood test (Date:)	(With the method) 1 positive 2 negative			
		Kidney function test (Date:)	PSP (15-min. measurement)		Concentration test maximum urinary specific gravity	
		Basal metabolism measurement (Date:)				
		Glucose measurement (Date:)	Fasting mg/dL		Sugar tolerance test (g) Before (mg/dL) 60 min. after (mg/dL) 120min. after (mg/dL)	
		Lung function test (Date:)	Breathing capacity cc		Percent per second	%
		Histopathological diagnosis (Date:)	(Pathological name)			
		Blood pressure measurement (Date:)	Systolic pressure mmHg		Diastolic pressure mmHg	

(Reverse side)

<table>
<tr><td rowspan="8"></td><td rowspan="8">Other tests</td><td>X-ray test</td><td colspan="2">Chest
(Date:)
(lung or heart)

CTR %</td><td colspan="2">Abdomen (Date:)</td><td colspan="3">Locomotorium (Date:)</td></tr>
<tr><td colspan="2">Electrocardiogram
(Date:)</td><td>ST</td><td></td><td>T</td><td></td><td>Abnormal cardiac rhythm</td><td></td><td>Others</td><td></td></tr>
<tr><td colspan="3">Endoscopic test
(Date:)</td><td colspan="6">(site:)</td></tr>
<tr><td rowspan="3">Ophthalmological test
(Date:)</td><td colspan="3">Presence/absence of lens opacification</td><td>1. presence
2. absence</td><td>Eyesight</td><td colspan="3">right ( )
left ( )</td></tr>
<tr><td colspan="3">Conditions of lens opacification</td><td colspan="5"></td></tr>
<tr><td colspan="3">Special instructions for onset of lens opacification</td><td colspan="5"></td></tr>
<tr><td colspan="2">Neurological function test
(Date:)</td><td colspan="3">Paralysis of limbs
1 presence 2 absence</td><td colspan="3">Difficulty in speech
1 presence 2 absence</td><td>Others</td></tr>
<tr><td colspan="2">Other special instructions</td><td colspan="8"></td></tr>
</table>

I hereby certify the diagnoses as mentioned above.

Date: / / (DD/MM/YY)

Name of medical institution:

Address:

Name of physician in charge: (Signature or Seal)

* The period of validity of this medical certificate is one month from the date of application.

Notes

1 Excepting “Name”, “Residence”, “Name of medical institution”, “Address”, and “Name of physician in charge”, please write in Japanese or English.

2 This certificate is necessary to determine whether a disease accompanied with disorders provided for by ordinance of the Ministry of Health, Labour and Welfare (disorders marked at *1) qualifies the sufferer for receipt of Health Management Allowance. Health Management Allowance is not provided in cases where it is apparent that the disease is no longer due to A-bomb radiation.

3 The disorder qualifying the sufferer for Health Management Allowance should usually cause some hindrance to carrying out one's daily life and the intended diseases are as follows;

(1) Disease accompanied by Hematopioetic dysfunction (Mainly, Aplastic anemia, Iron deficiency anemia)
(2) Disease accompanied by Liver dysfunction (Mainly, Liver cirrhosis)
(3) Disease accompanied by Dysfunction of cellular proliferation (Mainly, Malignant tumor)
(4) Disease accompanied by Endocrine dysfunction (Mainly, Diabetes mellitis, Hypothyroidism, Hyperthyroidism)
(5) Disease accompanied by Cerebrovascular dysfunction (Mainly, Subarachnoid hemorrhage, Cerebral hemorrhage, Cerebral infarction)
(6) Disease accompanied by Cardiovascular dysfunction (Mainly, Hypertensive heart disease, Chronic ischemic heart disease)
(7) Disease accompanied by Renal dysfunction (Mainly, Nephrotic syndrome, Chronic nephritis, Chronic renal failure, Chronic glomerulonephritis)
(8) Disease accompanied by Visual dysfuncton due to lens opacity (Mainly, Cataract)
(9) Disease accompanied by Respiratory dysfunction (Mainly, Emphysema, Chronic interstitial pneumonia, Pulmonary fibrosis)
(10) Disease accompanied by Motor dysfunction (Mainly, Arthrosis deformans, Spondylosis deformans)
(11) Disease accompanied by Digestive tract dysfunction due to ulceration (Mainly Gastric ulcers, Duodenal ulcers)

4 Please fill the results of the test in *3 that clearly show the condition of the disease entered in *2.

Medical Certificate for Health Allowance

<table>
<tr><td>Name</td><td colspan="3"></td><td>Date of birth (DD/MM/YY)
/ /</td><td>male/
female</td></tr>
<tr><td>Residence</td><td colspan="3"></td><td></td><td></td></tr>
<tr><td colspan="2">Name of injury or disease that caused disorder</td><td colspan="4"></td></tr>
<tr><td colspan="2">Describe your views for cases where it is clear that the injury or disease above was not attributable to A-bomb radiation.</td><td colspan="4"></td></tr>
<tr><td rowspan="8">*1
Status of physical disorder</td><td rowspan="2">Visual acuity</td><td rowspan="2">Right eye ( )
Left eye ( )</td><td rowspan="2">*2
Hearing</td><td>Loss of hearing (old standard)</td><td>Right db
Left db</td><td rowspan="8"></td></tr>
<tr><td>Level of hearing (new standard)</td><td>Right db
Left db</td></tr>
<tr><td colspan="3">Balance function disorder</td><td colspan="2"></td></tr>
<tr><td colspan="3">Audio-lingual function disorder</td><td colspan="2"></td></tr>
<tr><td colspan="3">Condition of the upper limbs</td><td colspan="2"></td></tr>
<tr><td colspan="3">Condition of the fingers</td><td colspan="2"></td></tr>
<tr><td colspan="3">Condition of the lower limbs</td><td colspan="2"></td></tr>
<tr><td colspan="3"></td><td colspan="2"></td></tr>
<tr><td colspan="3">*2 Comment, if the status of disorder above is physical one to the extent prescribed on the attached list 1 of the enforcement regulations of the law</td><td colspan="3">1. Corresponds to number ( ) of the attached list 1
2. Not correspond to the attached list 1</td></tr>
<tr><td colspan="3">Comment on whether the disorder above is persistent or not</td><td colspan="3">1. Persistent
2. Not persistent</td></tr>
<tr><td colspan="6">I hereby certify the diagnoses as mentioned above.

Date: / / (DD/MM/YY)

Name of medical institution:

Address:

Name of physician in charge: (Signature or Seal)

* The period of validity of this medical certificate is one month from the date of application.</td></tr>
</table>

Looks of face and head

Trunk disorder	
Other functional disorder	
Internal disorder	
Part	
Condition	

Notes

1 Excepting “Name”, “Residence”, “Name of medical institution”, “Address”, and “Name of physician in charge”, please write in Japanese or English.
2 Please indicate the conditions of the disorder in *1.
3 Please refer to the reverse side about the attached list 1 of *2 and mark the number 1or 2 that corresponds.

(Reverse side)

Attached list 1

1. The sum of eyesight of both eyes is 0.08 or less.

2. Loss of hearing in both ears is 80 db or more.

3. Considerable dysfunction of balance

4. Loss of audio or lingual function

5. Loss of thumb or forefinger on upper limbs

6. Considerable dysfunction of thumb or forefinger on upper limbs

7. Considerable dysfunction on left or right of upper limb

8. Loss of all fingers on left or right upper limb

9. Loss of function of all fingers on left or right limb

10. Loss of lower limbs from Chopart joints

11. Considerable dysfunction on lower limbs

12. Loss of over half of thigh in left or right lower limb

13. Loss of the function on left or right lower limb

14. Considerable trunk dysfunction so as to cause difficulty in walking

15. Physical dysfunction or condition necessitating rest imposes as much restriction on daily life as those listed above, to the extent that daily life is severely restricted or necessitates the imposition of restrictions.

16. Cases where physical dysfunctions or conditions are duplicated and impose as much restriction as those listed above

17. Disfigurement of head, face,etc severely restricting daily life

Remarks

Eyesight should be measured using the Universal eye-sight chart. In cases of abnormal refraction, it is corrected eyesight that should be tested.

Medical Certificate for Special Medical Care Allowance

Name		Date of birth (DD/MM/YY) / /	male/ female
Residence			

*1 Name of injury or disease and date of authorization about the 1st clause of Article 11 of the law	

*2 Present findings regarding the injury or disease above	1) Physical test
	2) Clinical pathological test
	3) Other test
	4) Other special instructions

Present status of injury or disease above	{ ( ) In the condition of ( ) Not In the condition of } injury or disease above

I hereby certify the diagnoses as mentioned above.

Date: / / (DD/MM/YY)

Name of medical institution:

Address:

Name of physician in charge: (Signature or Seal)

* The period of validity of this medical certificate is one month from the date of application.

Notes

1. Excepting “Name”, “Residence”, “Name of medical institution”, “Address”, and “Name of physician in charge”, please write in Japanese or English.
2. Please fill in comments in *2 indicating the status of injury or disease entered in *1.

Medical Certificate for Atomic Bomb Microcephaly Allowance

<table>
<tr><td colspan="3">Name</td><td></td><td colspan="2">Date of birth (DD/MM/YY)
/ /</td><td>male/
female</td></tr>
<tr><td colspan="3">Residence</td><td colspan="5"></td></tr>
<tr><td colspan="3">Symptoms of microcephaly</td><td colspan="5">Positive / Negative</td></tr>
<tr><td colspan="3">In cases where it is clear that the microcephaly is not a result of A-bomb radiation, describe your views.</td><td colspan="5"></td></tr>
<tr><td colspan="3" rowspan="2">Condition at birth</td><td colspan="3">Gestational age at birth</td><td colspan="3">Birth weight</td></tr>
<tr><td colspan="3">weeks</td><td colspan="3">g</td></tr>
<tr><td colspan="3" rowspan="2">Anamnesis</td><td colspan="3">Epilepsy</td><td colspan="3">Others</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td colspan="3">Condition of growth retardation</td><td colspan="5"></td></tr>
<tr><td rowspan="8">Present status</td><td colspan="2">Height</td><td>cm</td><td>Weight</td><td>kg</td><td>Head</td><td>cm</td></tr>
<tr><td rowspan="5">Physical findings</td><td>Head</td><td colspan="5"></td></tr>
<tr><td>Eye</td><td colspan="5"></td></tr>
<tr><td>Skin</td><td colspan="5"></td></tr>
<tr><td>Spine</td><td colspan="5"></td></tr>
<tr><td>Extremities</td><td colspan="5"></td></tr>
<tr><td colspan="2">Life adaptability</td><td colspan="5"></td></tr>
<tr><td colspan="2">Other comments</td><td colspan="5"></td></tr>
<tr><td colspan="3">Other special instructions</td><td colspan="5"></td></tr>
<tr><td colspan="3">Comments, if the mental or physical disorder relating to microcephaly is such that daily life is severely restricted or necessitates the imposition of severe restrictions</td><td colspan="5"></td></tr>
</table>

I hereby certify the diagnoses as mentioned above.

Date: / / (DD/MM/YY)

Name of medical institution:

Address:

Name of physician in charge: (Signature or Seal)

(The period of validity of this medical certificate is one month from the date of application.)

Note

Excepting “Name”, “Residence”, “Name of medical institution”, “Address”, and “Name of physician in charge”, please write in Japanese or English.

Application Form for Direct Bank Transfer

Date: _____/____/_____(DD/MM/YY)

To:_____

A-bomb survivor's certificate number

_____

Beneficiary name

_____

Beneficiary address

_____

Please transfer the Allowance to the following account.

Please fill in:

Paying Bank	
BIC Code, IBAN Code, etc.	
Branch Name	
Address	
Country	
Account No.	
Account Name	
Beneficiary Telephone Number	
Beneficiary Country	

* Please write in BLOCK CAPITALS.

POWER OF ATTORNEY

Date: _____/____/_____(DD/MM/YY)

To:_____

Entrusted Person

Address_____

Name_____

(Seal or signature)

A-bomb survivor's certificate number

_____

I hereby entrust the agent named below with complete power of attorney over matters concerning documents necessary to apply for _____ Allowance.

Please fill in:

Agent

Address_____

Name_____(Seal)

Signature_____

STATEMENT

Date: _____/____/_____(DD/MM/YY)

To:_____

Address_____

Name_____

(Seal or signature)

A-bomb survivor's certificate number

_____

I hereby state that I am unable to come to the office in person.
(Embassy/ Consulate-General of Japan in _____)

Contents of statement (in detail)

Notification of Change of Name

To:_____

Date: ____/____/____(DD/MM/YY)

I hereby notify a change of name as follows.

A-bomb survivor's certificate number	Name	Date of birth	Sex
	(Signature or seal)	/ /	Male/ Female
Name before change			
Name after change			
Date of change	/ / (DD/MM/YY)		
Notes			

* Please attach a certificate of name change issued by a public institution.

Notification of Change of Address

To:_____

Date: ____/____/____(DD/MM/YY)

I hereby notify a change of address as follows.

A-bomb survivor's certificate number	Name	Date of birth	Sex
-	(Signature or seal)		Male/ Female
New address			
Previous address			
Date of change	/ / (DD/MM/YY)		
Notes			

Notification of Death

To:_____

Date: ____/____/____(DD/MM/YY)

Name	(Signature or seal)	Relationship to deceased A-bomb survivor	
Residence	Address Phone number		

Deceased person	Name	
	Residence at time of death	
	A-bomb survivor's ceritificate number	
	Date of death	/ / (DD/MM/YY)

* Please attach a document evidencing death (e.g. a copy of death certificate).
* Please return the A-bomb survivor's certificate and allowance certificate(s).

Please sign and put your signature/seal below if you have lost the A-bomb survivor's certificate.

Notification of the loss of Atomic Bomb Survivor's Certificate

I hereby notify the loss of Atomic Bomb Survivor's Certificate.

Name of this notification

(Signature or seal)

Questionnaire for Medical Institution

1 Regarding Medical Institution

Name of country or region		Name of office	
Name of medical institution			
Address			
Telephone number			

2 Diagnosis and test availability

(1) Diagnosis (Check the ☐ of diagnosable disease)

Disability		Disease
(1)	Hematopoietic dysfunctoin	☐Aplastic anemia, ☐Iron deficiency anemia
(2)	Liver dysfunction	☐Liver cirrhosis
(3)	Dysfunction of cellular proliferaton	☐Malignant tumor
(4)	Endocrine dysfunction	☐Diabetes mellitis, ☐Hypothyroidism, ☐Hyperthyroidism
(5)	Cerebrovascular disorder	☐Subarachnoid hemorrhage, ☐Cerebral hemorrhage, ☐Cerebral infarction
(6)	Cardiovascular dysfunction	☐Hypertensive heart disease, ☐Chronic ischemic heart disease
(7)	Renal dysfunction	☐Nephrotic syndrome, ☐Chronic nephritis, ☐Chronic renal failure, ☐Chronic glomerulonephritis
(8)	Visual dysfunction due to lens opacity	☐Cataract
(9)	Respiratory dysfunction	☐Emphysema, ☐Chronic interstitial pneumonia, ☐Pulmonary fibrosis
(10)	Motor dysfunction	☐Arthrosis deformans, ☐Spondylosis deformans
(11)	Digestive tract dysfunction due to ulcer	☐Gastric ulcer, ☐Duodenal ulcer

(2) Test (Check the ☐ of available test)

Category of test	
(1)	Hematological test
	☐ Peripheral blood (Hemoglobin count, Granulocyte count, Erythrocyte count, Pathological cell, Rericulocyte count, Platelet count, Leukocyte count)
	☐ Bone marrow (Nuclear cell count, Megakaryocyte count, Lymphocyte)
(2)☐	Liver function test (TP, A/G, Bilirubin, GOT, GPT, LDH, ALP, ZTT, ICG)
(3)☐	Urinalysis (Opacity, Glucose, Protenuria, Urobilinogen)
(4)☐	Stool occult blood test
(5)☐	Kidney function test (PSP, Concentration test maximum urinary specific gravity)
(6)☐	Basal metabolism measurement
(7)☐	Glucose measurement (Fasting, Sugar tolerance test (Before, 60min. After, 120min. After))
(8)☐	Lung function test (Breathing capacity, Pecent per second)
(9)☐	Histopathological diagnosis
(10)☐	Blood pressure measurement (Systolic pressure, Diastolic pressure)
(11)☐	X-ray test (Chest, Abdomen, Locomotorium)
(12)☐	Electrocardiogram (ST, T, Abnormal cardiac rhythm)
(13)☐	Endoscopic test
(14)☐	Ophthalmological test (Eyesight, Presence/Absence of lens opacification, Condition of lens opacification)
(15)☐	Neurological function test (Paralysis of limbs, Difficulty in speech)

3 Remarks

* For cases where a disease or test not listed above 2(1) or (2) is to be specified on the medical certificate, please indicate whether or not you can able to diagnose or test for it.

I hereby answer the questionnaire as above.

Date / / (DD/MM/YY) Name

(Signature or seal)