

JAPAN Pre-Entry Tuberculosis (TB) Screening Clearance Certificate
結核非発病証明書

Certificate Number: VN0162025308319
(証明書番号)

 E C H I G O 越 DU HỌC NHẬT BẢN	First Name(s)* : (名) XXXX	Middle Name(s)* : (ミドルネーム) XXXX	Family Name(s)* : (姓) XXXX
	Date of Birth (dd-mmm-yyyy): (生年月日) 07-Jun-2010	Sex: <input type="checkbox"/> Male (男) <input checked="" type="checkbox"/> Female (女) <input type="checkbox"/> Others(その他) (性)	Age on the application date (申請時における年齢) 15
Mode of Personal Identification: <input checked="" type="checkbox"/> Passport(パスポート) (本人確認書類)		Country of Nationality: (国籍) Viet Nam	Note: *As shown in the identification document (本人確認書類に記載のとおり)
Passport Information (パスポート情報)	Passport Number: (パスポート番号) P00384222	Country of Issue: (発行国) Viet Nam	Passport Expiration Date (有効期限) 10-Aug-2027


I certify that all the above statements regarding the applicant are true.
(申請者に関する上記全項目が真実であることを証明します。)

I certify that this applicant has been screened for TB and has not been found to have active TB.
(申請者が入国前結核健診を受診し、その結果活動性結核が診断されなかったことを証明します。)

Name of Panel Clinic : IOM Migration Health Assessment Centre -
(指定医療機関名) Ho Chi Minh City

Name of Panel Physician:
(医師の氏名) NGUYEN, Lan Thuy

Panel Clinic ID:
(指定医療機関ID) VN016

Signature(署名): 

This Certificate was issued on (dd-mmm-yyyy)
(証明書の発行日) 15-Jul-2025

and is valid until(dd-mmm-yyyy)
(証明書の有効期限) 11-Jan-2026



IMPORTANT NOTICE TO THE APPLICANT:

This certificate is to be submitted to the diplomatic missions abroad or the Regional Immigration Bureau, together with application forms for visa/Certificate for Eligibility. This certificate contains information in connection with your application for visa/Certificate for Eligibility to stay for Japan and does not constitute a diagnosis or assurance of health. Issuance of the certificate does not mean that your application for visa/Certificate for Eligibility will be successful.



JAPAN PRE-ENTRY TUBERCULOSIS SCREENING PROGRAMME

Pre-Entry Tuberculosis Screening Results Report

申請者の入国前結核健診 結果に関する情報提供書



BIOGRAPHIC INFORMATION		
Reference ID: VNJP202500019514		
Applicant's Name:	XXXX	XXXX XXXX
	[First Name(s)]	[Middle Name(s)] [Family Name]
Date of Birth: (dd-mmm-yyyy):	07-Jun-2010	Sex: <input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> Others
Nationality: Viet Nam		
Passport Number: P00384222		

Dear Colleague, ご担当者様

I write to inform you of the test results for the above-mentioned Applicant, who underwent Japan pre-entry TB screening as part of the application process of the Certificate of Eligibility / visa for mid- to long-term stay in Japan.


上記の申請者は、日本入国前結核健診を受けました。結果の詳細を以下の通りお知らせいたします。

HISTORY & PHYSICAL EXAMINATION	
Exam Date: 15-Jul-2025	
Cough <input checked="" type="radio"/> No <input type="radio"/> Yes	Sputum Expectoration <input checked="" type="radio"/> No <input type="radio"/> Yes
Night Sweats <input checked="" type="radio"/> No <input type="radio"/> Yes	Hemoptysis <input checked="" type="radio"/> No <input type="radio"/> Yes
Weight Loss <input checked="" type="radio"/> No <input type="radio"/> Yes	Fever <input checked="" type="radio"/> No <input type="radio"/> Yes
Lymphadenopathy <input checked="" type="radio"/> No <input type="radio"/> Yes	
History of TB	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Anyone in the household diagnosed with active pulmonary TB	<input checked="" type="radio"/> No <input type="radio"/> Yes (If yes, in the last 2 years? <input type="radio"/> No <input type="radio"/> Yes) <input type="radio"/> Unknown
History of contact with active pulmonary TB, if known	<input checked="" type="radio"/> No <input type="radio"/> Yes (If yes, in the last 2 years? <input type="radio"/> No <input type="radio"/> Yes) <input type="radio"/> Unknown
History of or currently immune compromised	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
History of or currently using immunosuppressant agents	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
History of chronic disease, history of previous thoracic surgery/cyanosis, respiratory insufficiency that limits activity? (5 to below 15 years only)	<input type="radio"/> No <input type="radio"/> Yes
Chest Auscultation	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal (specify) <input type="radio"/> Not Done
Examination of the Neck	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal (specify) <input type="radio"/> Not Done
Remarks - Medical History:	

Reference ID:

VNJP202500019514

Applicant's Name (First / Middle Thanh | Phuoc | LAM
/ FAMILY NAME):

TST/IGRA TEST (< 5 years only) ● Not done ○ Done ○ Pending									
TST	Date Applied (dd-mmm-yyyy):					Date Read (dd-mmm-yyyy):			
	Result (mm):					Interpretation: ○ Negative ○ Positive			
IGRA	Date of Blood Drawn (dd-mmm-yyyy):								
	Interpretation: ○ Negative ○ Positive ○ Indeterminate or Invalid								
	QFT	Nil (IU/ml)		T-SPOT	Nil (Spots)		Wantai	N (Background Control, pg/ml)	
		TB1 (IU/ml)			A-Nil (Spots)			P (Positive Control, pg/ml)	
		TB2 (IU/ml)			B-Nil (Spots)			TB-IGRA	T (Testing, pg/ml)
Mitogen (IU/ml)			Positive Control (Spots)						
CHEST X-RAY: ○ Not done ● Done ○ Pending									
Date of Chest X-ray (dd-mmm-yyyy): 15-Jul-2025						Name of Radiologist: SUN, Maria Lena Ablis			
Chest X-ray Interpretation	Findings: ● Normal ○ Abnormal ○ Pending								
	Details: - Normal chest								
BACTERIOLOGICAL TEST ● Not done ○ Done ○ Pending									
Collection Date	Report Date	Smear Results	Culture Results	Molecular Test Results, if done					
PANEL PHYSICIAN									
Panel Physician Name: NGUYEN, Lan Thuy			Signature: 				Date (dd-mmm-yyyy): 15-Jul-2025		
Name of Panel Clinic: IOM Migration Health Assessment Centre - Ho Chi Minh City			Address: 1B, Pham Ngoc Thach St, Ben Nghe Ward, District 1 Ho Chi Minh City				Tel: 8428 3822 2057		



JAPAN PRE-ENTRY TUBERCULOSIS SCREENING PROGRAMME

Chest X-ray Report



REGISTRATION DETAILS	
Reference ID	VNJP202500019514
Exam Date	15-Jul-2025
City of TB Assessment	Ho Chi Minh City
Country of TB Assessment	Viet Nam
Panel Clinic Name	IOM Migration Health Assessment Centre - Ho Chi Minh City
Panel Clinic ID	VN016

BIOGRAPHIC INFORMATION		
Applicant's Name:	XXXXXX	XXXXXX
	[First Name(s)]	[Middle Name(s)]
		XXXXXX
		[Family Name]
Date of Birth (dd-mmm-yyyy):	07-Jun-2010	Sex: <input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> Others
Nationality:	Viet Nam	
Passport Number:	P00384222	

CHEST X-RAY DETAILS	
Date of Chest X-ray (dd-mmm-yyyy):	15-Jul-2025
Radiologic Technologist Name:	HINH, Cuong Ich
Chest X-ray view	Standard view(s): PA CXR
	Additional view(s), specify:
Other details, if applicable	<input checked="" type="checkbox"/> With pelvic shielding <input type="checkbox"/> Other (specify):

CHEST X-RAY INTERPRETATION
Chest X-ray Findings: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
A. Findings likely to suggest active TB: <input type="checkbox"/> No <input type="checkbox"/> Yes (Choose below)
<input type="checkbox"/> A-1 Cavitary lesions
<input type="checkbox"/> A-2 Consolidation or ill-defined soft tissue infiltration
<input type="checkbox"/> A-3 Miliary lesions
<input type="checkbox"/> A-4 Multiple / single ill-defined soft tissue nodules or masses
<input type="checkbox"/> A-5 Soft tissue hilar or mediastinal mass / lymphadenopathy
<input type="checkbox"/> A-6 Pleural effusion
B. Findings sometimes seen in active TB: <input type="checkbox"/> No <input type="checkbox"/> Yes (Choose below)
<input type="checkbox"/> B-1 Fibronodular / fibrocalfic / fibrocystic lesions or localized multiple calcific nodules with or without volume loss
<input type="checkbox"/> B-2 Multiple / single well-defined pulmonary nodules or masses (non-calcified)
<input type="checkbox"/> B-3 Notable apical pleural capping (rough or ragged inferior border) and/or pleural thickening \geq 1cm thickness at any point
C. Minor findings which may be associated with old / healed TB: <input type="checkbox"/> No <input type="checkbox"/> Yes (Choose below)
<input type="checkbox"/> C-1 Solitary calcified nodule
<input type="checkbox"/> C-2 Calcified hilar lymph node(s)
<input type="checkbox"/> C-3 Multiple calcified pulmonary nodules with distinct borders (scattered)
<input type="checkbox"/> C-4 Calcified pleural lesions
<input type="checkbox"/> C-5 Costophrenic angle blunting (either side above the horizontal)*
*Note: Take lateral decubitus CXR, if effusion is suspected.

Reference ID: VNJP202500019514

Applicant's Name (First / Middle /
FAMILY NAME):

Thanh | Phuoc | LAM

D. Minor findings, likely not associated with TB: No Yes (Choose below)

- D-1 Single linear streak
- D-2 Smooth pleural thickening, apical and/or lateral (< 1cm thickness at all points)
- D-3 Unilateral or bilateral costophrenic angle blunting (below the horizontal)*
- D-4 Others, specify:

*Note: Take lateral decubitus CXR, if effusion is suspected.

E. Suggestive of significant non-TB findings: No Yes (Choose the applicable anatomical part(s) below and describe the findings in the remarks.)

- E-1 Soft tissue and bones
- E-2 Heart and great vessels
- E-3 Diaphragm, costophrenic angles and pleura
- E-4 Hilar and mediastinum
- E-5 Lung fields
- E-6 Others, specify:


*Note: The cut off point for cardiomegaly: CTR \geq 55% for adults and \geq 60% for children. Specific chamber enlargement should also be checked as abnormal even if normal CTR.

Remarks (Describe all abnormal findings in the Chest X-ray):

Normal chest

RADIOLOGIST DETAILS

Radiologist Name: SUN, Maria Lena Ablis

Radiologist
Signature: 

Date of Chest X-ray Reading (dd-mmm-yyyy): 15-Jul-2025

CHEST X-RAY REVIEW BY PANEL PHYSICIAN

Panel Physician Remarks

Panel Physician Name: NGUYEN, Lan Thuy

Panel Physician Signature:



Review Date (dd-mmm-yyyy): 15-Jul-2025

INSTRUCTION TO PANEL PHYSICIANS:

The Panel Physician should request the applicant to submit a set of 3 sputum specimens in the following scenarios:

1. If any of the CXR findings under A or B is identified.
2. If any CXR findings under C are identified and the Applicant shows clinical signs and symptoms suggestive of pulmonary TB irrespective of the duration or if the Applicant has a history of active TB.
3. If any CXR findings under D, E, or normal CXR findings are identified and the Applicant shows typical signs and symptoms suggestive of pulmonary TB such as prolonged cough for 2 weeks or more or if the Applicant has a history of active TB.