

Essay Questions

The following essay questions will provide us with more information about you and your reasons for applying to the Young Leaders' Program.

Your essays must be typed. Please use A4-size paper or 8 1/2" × 11" paper. Strictly limit your responses to the maximum number of words designated for each question. Use standard double-spaced lines. Your name should appear at the top of each separate sheet of paper. The number of the essay question should precede every essay. Staple the essays together and submit them with the other application materials.

1. What are your most significant accomplishments, activities, and life experiences to date? Please emphasize the events which highlight your unique abilities and personality. (maximum 500 words)
2. What is your leadership philosophy? Describe key individuals and/or experiences that shaped your philosophy. (maximum 500 words)

Supplemental Question

3. How did you become interested in the Young Leaders' Program? Please list specific information sources such as publications, alumni, faculty, and websites. (maximum 200 words)

健康診断書 (2024年度版)

(医師に記入してもらうこと)

日本語又は英語により明瞭に記載すること。

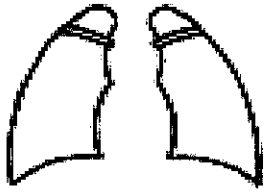
CERTIFICATE OF HEALTH (for 2024)

(to be completed by the examining physician)

Please fill out (PRINT/TYPE) in Japanese or English.

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|--------------|--|-----------------------|---------------------|
| 氏名 Name | Sumame 姓 | Given name 名 | Middle name ミドルネーム |
| 性別 Gender | <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female | 生年月日 Date of Birth | 年 月 日 yyyy mm dd |

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|---------------------------------|---|--------------------------------|--|
| 1. 身体検査 Physical examination | | | |
| (1) 身長 Height | cm | (2) 体重 Weight | kg |
| (3) 血圧 Blood pressure | mmHg~ mmHg | (4) 血液型 Blood type | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> RH+ <input type="checkbox"/> RH- |
| (5) 脈拍 Pulse | <input type="checkbox"/> 整 Regular <input type="checkbox"/> 不整 Irregular | (7) 色覚異常の有無 Color blindness | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |
| (6) 視力 Eyesight | 裸眼 (右) (左) Without glasses (R) (L) 矯正 (右) (左) With glasses or contact lenses (R) (L) | (8) 聴力 Hearing | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |
| | | (9) 言語 Speech | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |

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| 2. 胸部聴診及びX線検査 (6ヶ月以内) Physical and X-ray examinations of the chest (within six months) | | | |
|  | 胸部X線所見 Describe the condition of lungs. | 撮影年月日 Date of X-ray | 年 月 日 yyyy mm dd |
| | | フィルム番号 Film No. | |
| | | (1) 肺 Lungs | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |
| | (2) 心臓 Cardiomegaly | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired | |
| | | 異常がある場合⇒心電図 If impaired⇒Electrocardiograph | <input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |

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| 3. 現在治療中の病気 Disease currently being treated | <input type="checkbox"/> 無 No <input type="checkbox"/> 有 Yes : 病名 Disease |
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|--|------------|--------------------------------------|---|---|--|---|
| 4. 既往症 Past illness/disorder | ✓ | 病名 Name | 完治時期/治療中 Date of recovery /under treatment | ✓ | 病名 Name | 完治時期/治療中 Date of recovery /under treatment |
| 該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は下記「無し」にチェックすること。 Please check and fill in the date of recovery/under treatment. If NOT contracted any of them in the past, please check "None" below. | | 結核 Tuberculosis | | | マラリア Malaria | |
| | | その他感染症 Other communicable disease | | | てんかん Epilepsy | |
| | | 腎疾患 Kidney disease | | | 心疾患 Heart disease | |
| | | 糖尿病 Diabetes | | | 薬剤アレルギー Drug allergy | |
| ✓ | | 精神疾患 Psychosis | | | 四肢機能障害 Functional disorder in the extremities | |
| | 無し None | | | | | |

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| 5. ワクチン接種歴 Vaccination History | MMRV (Measles, Mumps, Rubella, Zoster)... <input type="checkbox"/> Time(s) () MMR (Measles, Mumps, Rubella)... <input type="checkbox"/> Time(s) () MR (Measles, Rubella)... <input type="checkbox"/> Time(s) () M (Measles)... <input type="checkbox"/> Time(s) () | Mumps... <input type="checkbox"/> Time(s) () Chicken pox... <input type="checkbox"/> Time(s) () Polio... <input type="checkbox"/> Time(s) () Diphtheria Pertussis Tetanus combined... <input type="checkbox"/> Time(s) () | Hepatitis B... <input type="checkbox"/> Time(s) () Meningitis... <input type="checkbox"/> Time(s) () |
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|---------------------------|--------------|---------------|--------------------|--------|--------------------|--------|--------------|
| 6. 検査 Laboratory tests | | | | | | | |
| (1) 尿検査 Urinalysis | 糖 glucose | 蛋白 protein | 潜血 occult blood | | | | |
| (2) 貧血検査 Anemia test | 赤沈 ESR | mm/Hr | 白血球数 WBC count | /cmm | 血色素量 Hemoglobin | gm/dl | 貧血 Anemia |
| (3) 肝機能検査 LFT | GPT (ALT) | (IU/l) | GOT (AST) | (IU/l) | γ-GTP | (IU/l) | |

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| 7. 医師の診断・意見 Physician's impression of the applicant's health 継続的治療・投薬の必要性があればその旨ご記入下さい。 Please fill in if the applicant needs regular medication or treatment. |
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| 8. In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan? 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は十分に留学に耐えうるものと思われますか? <input type="checkbox"/> YES (はい) <input type="checkbox"/> NO (いいえ) ※ Please be sure to check either "YES" or "NO". If you do not check "YES", the Embassy will NOT accept the application. 必ず「はい」又は「いいえ」にチェックしてください。「はい」にチェックがない場合、大使館は申請を受理しません。 | 日付 Date | |
| | 医師署名 Physician's Signature | |
| | 検査施設名 Office/Institution | |
| | 所在地 Address | |