

Akasaka Odayaka Clinic  
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Date of issue(交付年月日)    day/ month /2021

## *Certificate of testing for COVID-19*

Name(氏名): \_\_\_\_\_

Passport number: \_\_\_\_\_

Nationality(国籍): Japan

Gender(性別): Male / Female

Date of Birth(生年月日): Day/ Month / Year

This is to certify the following results which have been confirmed by testing for COVID-19 conducted with the sample taken from the above-mentioned person.

(上記の者の COVID-19 に関する検査の結果は、下記のとおりである。よって、この証明書を交付する。)

Sample (採取検体)	Testing for COVID-19 (検査方法)	Result (結果)	Sampling date (検体採取日時)	Result date (結果決定年月日)
Saliva	Real time RT-PCR	Negative	Day/month/year	Day/month/year

Physician(医師名): Hiroto Nishizawa MD, PhD

Medical Registration Number: 409257

Signature : \_\_\_\_\_

法人印