**Health Check-up Application Form**

(For Japanese Medical Insurance Holder)

**健康診断申込書 在日健康保険証保持者用**

**\*Please fill out the following form.** （以下ご記入願います）

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name 氏名 | | | Last name (姓)  in ''KATAKANA'' | | | ｶﾅ姓 | | | | | Sex  性別 |
| First name (名)  in “KATAKANA” | | | ｶﾅ名 | | | | | □M  □F |
| Nationality  国籍 | | | | |  | | | | | | |
| Date of birth  生年月日 | | | | | mm dd yyyy | | | | Language  言語 |  | |
| Address  (to which the documents will be sent)  書類の送り先 | | | | |  | | | | Contact phone number  電話番号 |  | |
| E-mail | | | | @ | | | | | | | |
| Please attach the photo or copy of your medical insurance card.　**(both sides)**  健康保険証の写真またはコピーを添付してください | | | | | | | □ Attached a photo 写真添付  □　Attached a copy 　コピー添付 | | | | |
| Please let us know your payment method.  支払い方法をお知らせください | | | | | | | □ At counter on the examination day当日窓口  □　Cover by your employer 　会社負担 | | | | |
| Estimated schedule (desired date) 予定日/希望日 | | | | | | | | | | | |
| 1 | | mm dd yyyy | | | | | 3 | mm dd yyyy | | | |
| 2 | | mm dd yyyy | | | | | 4 | mm dd yyyy | | | |
| **Please choose your desired course** コース選択  **※All mentioned costs are including tax.** 価格は全て税込みです。 | | | | | | | | | | | |
| □ | **①Annual medical check –up for Employer**会社の定期健診 | | | | | | | | | | |
| □ | **②MINATO-KU Health Check-up** 港区健診 | | | | | | Name of coupon:  or attach photos of your coupon. | | | | |
| □ | **③Lifestyle disease course \25,200** 生活習慣病予防健診 | | | | | | | | | | |
| □ | **④Basic A course \12,100** 法定健診 | | | | | | | | | | |
| □ | **⑤Basic B course \6,050** 簡易健診 | | | | | | | | | | |
| □ | **⑥1day regular course \48,400**日帰りドック | | | | | | | | | | |
| □ | **⑦1day express course basic \68,500**  　\*Only on Friday acceptable  日帰りエキスプレスドック　基本 （月・水・金曜日のみ） | | | | | | | | | | |
| □ | **⑧1day express course cancer check \101,500**  　\*Only on Friday acceptable  日帰りエキスプレスドック　がんチェック （月・水・金曜日のみ） | | | | | | | | | | |
| □ | **⑨1day express course arteriosclerosis check \123,500**  　\*Only on Friday acceptable  日帰りエキスプレスドック　動脈硬化チェック （月・水・金曜日のみ） | | | | | | | | | | |
| □ | **⑩　2days course　Grand Prince Hotel Shin-Takanawa \102,795**  \* With dinner at “Shimizu” Japanese Restaurant or “Kokiden” Chinese Restaurant  Twin room for 1 guest  １泊２日ドック：グランドプリンスホテル新高輪　1名利用 | | | | | | | | | | |
| □ | **⑪　2days course Shinagawa Tobu Hotel ￥79,970**  \* With dinner at “DA Noi Takanawa” Italian Restaurant. Single room for one guest  １泊２日ドック：品川東武ホテル　1名利用 | | | | | | | | | | |
| □ | **⑫　2days course Tokyu Stay Gotanda ￥75,350**  \* With dinner at family restaurant “Jonathan’s”. Single room for one guest  １泊２日ドック：:東急ステイ五反田　1名利用 | | | | | | | | | | |
| **Additional service request** 追加サービスの希望 | | | | | | | | | | | |
| □ | **English interpretation service:**　※ \22,000 / 2 hours(1 unit) 通訳サービス希望 | | | | | | | | | | |
| □ | **English medical report:** 　※ \5,500 for course #①～⑤  翻訳サービス希望　　　　　 \11,000 for course #⑥～⑯ | | | | | | | | | | |

**Agreement健康診断同意**

* Please let us know if you have an interpreter coming along with you. Even so, we may still arrange our own interpreter to assist in order to ensure safety. If so, additional cost will be charged to you. （通訳を同伴する場合はお知らせください。安全のため必要に応じて当院通訳を手配することがございます。　その場合の追加料金はご負担いただきます。）
* All courses must start in the morning. （すべてのコースは午前中から始まります。）
* Certain optional examinations are available upon request on your health checkup day. Please contact us for details（健康診断の当日に、ご要望に応じて特定の検査を受けることができます。 詳しくはお問い合わせください。）.
* Cancellation policy（取り消し規約）

|  |  |
| --- | --- |
| The day of examination | 100% |
| ※A 10% surcharge will apply if you reschedule your health checkup for more than 3 times.  （健康診断の日程を3回以上変更する場合は、10％の手数料が加算されます。） | |

* It will take approximately 3 weeks for the medical report to be ready.

（結果報告書の準備に約3週間かかります。）

* All patients are required to follow our instructions in case of emergency.

（すべての患者は緊急の場合に私達の指示に従うように要求されています。）

**I agree to all the contents above and would like to have a health checkup at Tokyo Takanawa Hospital.** （上記の内容すべてに同意し、東京高輪病院での健康診断を希望します。）

mm dd yyyy Signature 〈署名〉