Admissions Committee
China Evangelical Seminary
Tel 886-3-2737477

School Health Record: Chest X-Ray (R/O TB)

Name_____ **Gender：** ☐**Male** ☐**Female**

Date of Birth_____

Date of Examination_____

Family/Personal History of TB_____

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Result of Chest X-Ray

Physician's Evaluation and Suggestion

_____

Physician Signature of physician **Please print name**

_____

Name of Practice **Telephone Number**

_____

Address of Practice

Official Seal