Emergency Assistance Japan

Request Form for Health Checkup in Japan

Reception at Bangladesh Office

Date of Contact: (D/M/Y) / / CASE NO.

Contact person's information

＊If the contact person is the applicant below, just type 'same as below'.

Contact person's Name: Mr/Ms _____ **E-mail:** _____

Phone Number: _____ **Mobile phone:** _____

Relationship with the applicant below: _____

Applicant's Information

Applicant's name: Mr/Ms _____ ☐ **Male** ☐ **Female**

Date of Birth as in Passport: _____ **Nationality:** _____

Actual Date of Birth(if it is deferent from the one in passport: _____

Address: _____
(Please print the postal address in case of sending official documents)

Phone number: _____ **Mobile phone:** _____

Occupation: _____

Company name you are working for: _____

Company phone number you are working for: _____

Passport: ☐ **Obtained →Passport Number:** _____ ***＊Please make sure to attach your passport copy***
☐ **Not obtained**

' Visa for medical Stay' Issuance Support: ☐ **Needed**
☐ **Not needed**

Native Language: _____

Interpreter: ☐ **Required →→→→→→→ Desired Language:** _____
☐ **Not required**

Any health concerns, a body part/body parts you want to check : _____

_____

_____

_____

_____

Desired or Feasible Period for Health Checkup in Japan:

_____

Medical Information of applicant

Past Medical History:

Period of time	Diagnosis:	Treatment:

Diseases/illness you are taking treatment at present:

Since when	Diagnosis:	Treatment:

Medication you are taking at present:

Name of medicine	What is this medicine for

＊If you have more than 5 kinds, please use another sheet and attach it.

Emergency Contact Person's information

Name: Mr/Ms_____**E-mail:** _____

Phone Number:_____**Mobile phone:**_____

Relationship with the applicant below: _____

Disclaimer

1. The intent of International Medical Coordination Services ("the Service") is to facilitate access to Japanese healthcare by foreign patients through medical visa support, medical institution referrals, translation and interpretation services, and other services. The Service neither guarantees the medical outcome of treatment nor the effectiveness of a treatment delivered by a hospital that it recommends. EAJ will not be held responsible for any incidence of medical malpractice, nor will it be held liable for any accidents occurring during transportation arranged by EAJ. Ultimate responsibility for the decision to travel to Japan in order to seek medical treatment shall reside solely with the patient.
2. The Service is reliant upon personal and medical information provided by the patient and/or by the patient's home country physician or medical institution. Mistakes or inaccuracies in the information thus provided may result in either the alteration or the abortion of the originally planned course of treatment.
3. The discovery of any disease or other medical condition not diagnosed prior to arrival in Japan or not reported in the medical information provided by the patient or the patient's physician may necessitate additional treatment incurring additional fees. Medical services are subject to discontinuation if these fees are not promptly paid.
4. The Service is subject to limitation or discontinuation due to natural disaster, war, or other force majeure.
5. Please be advised that scheduling of medical treatment can take time, and that the actual timing of treatment is contingent upon hospital availability, as well as upon flight availability and the successful completion of other travel-related arrangements.

2011/04/28 Y&P Comments

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION（医療情報開示承認書）

Patient Name 患者名: _____ Date of Birth 生年月日: _____

Hospital 医療機関: _____

I hereby acknowledge that I authorize the Hospital above to release healthcare information relevant to the arrangements of my medical treatments to **EMERGENCY ASSISTANCE JAPAN, Co Ltd. （"EAJ"）** **NRK-Koishikawa Bldg. 1-21-14, Koishshikawa,** **Bunkyo-ku, Tokyo 112-0002 Japan**	私は、上記の医療機関が私の治療の手配に関連する医療情報を以下の者に開示することについて承認したことを確認します。 **日本エマージェンシーアシスタンス株式会社（"EAJ"）** **〒112-0002 東京都文京区小石川 1-21-14** **NRK 小石川ビル**
Tel. 81-3-3811-8600 / Fax 81-3-3811-8183	**電話：03-3811-8600 / ファックス：03-3811-8183**
This authorization applies specifically to: ☒ Complete medical records and information relating to the following medical condition, treatment and dates: Medical Condition: Treatment: Date of Service: ☒ Pre-existent medical conditions / Prior medical history ☒ Medical Bills/ Legal Purposes / Insurance ☐ Other:	本承認書は特に下記の情報を対象とします。 以下の症状･治療･治療日に対する全ての医療記録･医療情報 症状: 治療: 治療日: 既往症情報/病歴 治療費/法的な目的/保険 その他:
I agree that the hospital above, the doctor and the party concerned release the following information should it be contained in my medical record: Acquired immune Deficiency syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services to EAJ or the party that EAJ designates. Unless otherwise revoked by my written form, this authorization will expire on the following date or event: one year after the date of signature. If a date or an event is not specified, this authorization will expire one year from my date of signature below. This authorization is voluntary. I understand that I can refuse to sign this authorization, and the hospital above and EAJ will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization except as allowed by laws or regulations. I understand that I may inspect or copy the protected healthcare information to be used or disclosed. I understand that I may revoke this authorization at any time by notifying the hospital above and EAJ, in writing of my revocation. I understand that the revocation will not apply to any information that is already released in reliance on this authorization. I agree that the healthcare information released under this authorization may be re-disclosed by EAJ and the party that EAJ designates to third parties. I hereby release EAJ and the party that EAJ designates from all liability and claim of any nature whatsoever pertaining to the disclosed of information as contained in the records released pursuant to this authorization. I acknowledge that a copy or facsimile of this authorization is considered valid as the original.	私は上記の医療機関、その医師及び関係者が、EAJ 又は EAJ が指名する者に対し、私の全ての疾病（AIDS/HIV、アルコール及び/又は薬物中毒治療、行動又は精神的疾患を含む）に関する記録を提供することに同意しています。 本承認書は、私が書面で破棄しない限り左記の日付又は事象をもって失効するものとします。日付又は事象が明記されていない場合、本承認書は下記の署名日から1年後に失効するものとします。 本承認書は任意のものです。私は、本承認書への署名を拒否することが可能であること、及び、上記の医療機関及び EAJ は、法令により許可された場合を除き、私が本承認書に署名することを私の治療、支払、登録又は利益享受の条件としないことを理解しています。また、私は、利用又は開示される保護された医療情報を精査又は複写できることを理解しています。 私は、上記の医療機関及び EAJ に対し書面で破棄の意思を通知することにより、いつでも本承認書を破棄することが可能であると理解しています。また、私は、上記の通知以前に開示された情報については、破棄の対象とならないことを理解しています。 私は、本承認書に基づいて開示された医療情報については、EAJ 又は EAJ が指名する者から第三者に開示され得ることに同意しています。 私は、EAJ 及び EAJ が指名する者が、本承認書に基づく情報開示に関連する如何なる責任及び損害賠償からも免除されることを認めます。なお、私は、本承認書の写し又はファックスも本書と同じ効力があると認めます。

Patient/Guardian Signature: Date:

被保険者/保護者の署名 _____ 署名日 _____

Printed Name: _____

被保険者/保護者の名前（英語･ブロック体）

If signed by a person other than the patient, relationship to the patient _____

被保険者以外の署名の場合、被保険者との関係（英語･ブロック体）

Consent Form for Personal Information Protection

In compliance with the Personal Information Protection Law and various related laws, Emergency Assistance Japan, Co., Ltd. (hereinafter referred to as the "EAJ") strictly manages the personal information received from our customers. Please sign in the space below after your name, address and today's date if you understand and agree to the policy outlined above.

1. Control of Personal Information

The Personal Information received by EAJ shall be controlled by the under undermentioned person.

Emergency Assistance Japan Co., Ltd.
Personal Information Protection Administrator
〒112-0002 1-21-14 Koishikawa, Bunkyo-ku, Tokyo
Tel: 03-3811-8121(Main)
E-Mail: Soudan@emergency.co.jp
10:00-16:00 (Monday through Friday, except for holidays)

2. Purpose and Use for Collection of Personal Information

EAJ shall handle the personal information only within the scope listed on【1】necessary to achieve the purpose of use listed on【2】below Unless approved by the law for the protection of personal information or other regarding law. If EAJ needs to change the purpose of use, EAJ shall inform the customer of the change or the revised privacy policy shall be posted on our home page.

【1】Business content

① Medical consulting service and Hospital booking service
② Assistance service for those who encounter illness, disaster, accident etc.
③ Commissioned service of road assistance.
④ Booking service for transportation, accommodation, restaurants, concerts, etc.
⑤ Commissioned service of purchasing, house maintenance, moving, domestic help
⑥ General travel consulting service under Travel Agency Act
⑦ Any and all businesses incidental to each of the foregoing.

【2】Purpose of Use

① To perform appropriate operation such as providing services, correspondence, claiming and payment, answering for inquiries and request in regards to the above mentioned business
② To operate product and service announcement, providing information, conducting survey, data collection and data analysis in regard to the above mentioned business
③ To perform the business consigned with other business operators in appropriate and smooth manner

3. Provision of Personal Data to Third Parties

EAJ does not provide personal data to third parties without consent, except for the following cases:

① When stated on Private Information Protection Law
② When EAJ provides to their entrusted company including the local assistance company based upon business necessity
③ When EAJ share with EAJ's group company or affiliated companies

4. Entrustment of the Handling of Personal Data

EAJ may entrust the business to their partner company which EAJ appointed to and signed non-disclosure agreement with EAJ based upon business necessity.

5. Sensitive Information

EAJ does not obtain, use, or provide to third parties information concerning health and/or medical history, (hereinafter referred to as "Sensitive Information"), except when pursuant to the relevant laws.

* "Sensitive Information" means the information prescribed in the article 6 of "Financial Services Agency ("FSA") Guidelines on Personal Information Protection"

6. Claims Procedures for Disclosure of use of Personal Information

EAJ shall accept the request concerning retained personal data, such as notification of the purpose of use, disclosure, revision, addition, deletion, suspension of use, or provision to third parties.

7.

I ☐agreed / ☐ disagreed the above mentioned statement.

Please sign below.

Date: _____

Signature:_____

Print name:_____

For underage customer, Statutory Agent Name: _____

Relationship:_____