For outside users

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(date) (year)

To the Director of

Institute for Cosmic Ray Research (ICRR)

University of Tokyo, Tokyo, JAPAN

I certify that

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Family) (First) (Middle)

Age \_\_\_\_\_\_\_\_\_\_\_\_\_

Sex ❒ Male ❒ Female

the above person is a radiation worker at

(affiliation at home country)

and he(she) takes regular health examination and education each year, and that the state of his(her) health permit him(her) to execute work at ICRR during the period

from

(date) (year)

Signature

Name (Print)

Status

Institution