INTERNATIONAL CERTIFICATE OF VACCINATION

Name______________

DOB______________________

This is to certify that this person has received the following vaccination.

Vaccine or prophylaxis	Date	Manufacturer and batch no. of vaccine or prophylaxis
Hepatitis A vaccine		KM Biologics Company, Limited
Hepatitis B vaccine		KM Biologics Co.,Ltd.
Measles-rubella combination vaccine		BIKEN foundation
Mumps		Daiichi Sankyo Company, Limited
DPT-IPV		BIKEN foundation
DPT		BIKEN foundation
Rabies vaccine		GlaxoSmithKline K.K.
Pneumococcal vaccine		MSD K.K.

This certifies that the above is true.

Issued Date_________________

Clinic name: CLINIC TEN SHIBUYA
Adress: #2F Nichiei Building, 2-20-12, Shibuya, Shibuya Ward, Tokyo, 150-0002, Japan
Telephone: +81-50-3196-4637

Doctor's Signature_________________________