SEAMEO Regional Tropical Medicine & Public Health Network
(SEAMEO TROPMED)

PERSONAL DATA/APPLICATION FORM
(Please TYPE or PRINT in Duplicate)

Affix
Photo Here

Course Title : _____

_____

Inclusive Dates : _____

_____

Venue/Place : _____

Sponsor: ☐ SEAMEO TROPMED Network ☐ WHO ☐ Self-Supporting
☐ Other (Specify)_____

B I O D A T A

Name of Applicant: **(Underline Family Name)**		Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Others	Nationality:	Religion:
Date of birth (Month/Day/Year):	Age:	Place of birth (City & Country):
ID/Passport No:	Issued at:	Date:
Home Address:		Telephone: Fax: E-mail:
Name & Address/Tel/Fax/E-mail of Person to be contacted in an emergency):		
Office Name & Address:		Telephone: Fax: E-mail:
Present Position/Occupation: Sector: ☐ Govt. ☐ Private ☐ NGO ☐ Self-Employed		
Level of Responsibility: ☐ Managerial ☐ Supervisory ☐ Support Staff		
Brief Description of Duties & Responsibilities:		
Percent (%) Devoted to: ☐ Teaching ☐ Research ☐ Services ☐ Others (Specify)		
Educational Attainment: Certificate/Degree(s) obtained, Date obtained: College: Post Graduate:		

Previous SEAMEO TROPMED Programmes/Courses attained, Inclusive Dates:
Awards, Other Fellowships Obtained Venue, Inclusive Dates:
Employment History (in chronological order from the most recent): Position, Institution/Employer, Inclusive Dates: (Use additional sheets if necessary)
Research Activities in the last 5 years (Title; Objectives; Funding; Brief Statement of Progress of Results):
Publications in the last 5 years (Books; Technical Papers; Popular Articles; Use additional sheets if necessary):
Membership in Honorary and Scientific Societies:

Language Proficiency (Please indicate if "Excellent", "Good", or "Fair"):

	Writing/Reading	Speaking	Both
English			
Others (Specify)			

State briefly reasons for taking the course:
Expected Employment/Position upon completion of the course:

I, hereby, declare under penalties of perjury that the answers given above are true and correct to the best of my knowledge and belief.

_____ _____

(Date) (Signature)

N.B. Please submit this to course organizer or TROPMED Central Office

Endorsement from Employer (Head of Department/Unit/Centre/Division)

Name of Employer :

Address :

Telephone No :

Email Address :

Signature/Dates :

IMPORTANT: 1. Submit one copy each of completed form to:

1.1. Secretary-General/Coordinator
SEAMEO TROPMED Network Office
420/6 Ratchawithi Road, Bangkok 10400 THAILAND
(Via Fax No. (66-2) 354-9144 or
Via E-mail: secretariat@seameotropmednetwork.org or
dang_il@hotmail.com)

1.2. TROPMED Center where the course is to be taken.

2. The application form must be accompanied by:

2.1. A Certificate of Health and

2.2. Certificate of English Language Proficiency, by duty designated Authorities

2.3. Transcript of Academic Records and other requirements

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(FOR OFFICIAL USE ONLY)

Action taken: ☐ Approved ☐ Disapproved ☐ Pending

REMARKS: _____

_____

By: _____

Reference No:_____

Date:_____

SEAMEO TROPMED NETWORK

CERTIFICATE OF HEALTH

Part I (Fill by the Applicant)

1. Name (Please Print):

2. Age: Date of Birth:

3. Address:

4. I.D. /Passport Number:
   Issued at:
   Date:

5. Medical History:
   5.1. Do you have any physical impairment?
   (if yes, please give details):

   5.2. Have you ever been treated for mental illness?
   (if yes, please give details):

   5.3. In the past two years, have you ever been sick or received medical treatment or physical check-up for blood chemistry, blood pressure, urine analysis, x-ray, heart or others? If yes, please give details (name of hospital or clinic, attending physician, disease, diagnosis, result and date)

6. I hereby declare that the above statements are true to my knowledge. If there is any false statement or any truth being withheld. I agree to be responsible to all expenses which will derive from the care of those conditions. I agree to the decision of the Faculty Board Committee to withdraw my student status if it is indicated.

Signed at: Date:

Applicant's Signature :

Part II (Fill by a Physician)

1. Name of Candidate :

   Age : Sex :

   Office Address :

   Residence Address :

2. Physical Examination:

   a. Height : Weight :

   b. Skin :

   c. Resiratory System :

   d. Circulatory System :

   Blood pressure : Systolic/ Diastolic

   Heart :

   e. Gastrointestinal System :

   Abdomen :

   Liver :

   Spleen :

   f. Central Nervous System :

   g. Other Systems :

3. Laboratory Tests:

   Urine Examination

   Specific gravity :

   Albumin :

   Sugar :

   Microscopic :

4. Report on X-ray examination of the chest:

5. Does the examination reveal any physical or mental abnormalities which may interfere with his/her study?

   No [ ]

   Yes [ ] Describe :

   Physician's Signature : Date :

   Physician's name (type or print) :

   Official Address :

Note: 1.The Physician has to be a clinician in a government hospital
2. Please attach this Certificate of Health to the application form
3. The Certificate should have the seal of the same government hospital