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/University: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:

Secretariat

SEAMEO TROPMED Network Malaysia

Institute for Medical Research

National Institutes of Health

Ministry of Health, Malaysia

Via E-mail: seameo@moh.gov.my or fasihah.amir@gmail.com

1. The application form must be accompanied by:
	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:

1. Medical History:
	1. Do you have any physical impairment?

(if yes, please give details):

* 1. Have you ever been treated for mental illness?

(if yes, please give details):

* 1. 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)

1. 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:

1. Physical Examination:

a. Height: Weight:

b. Skin:

c. Respiratory System:

d. Circulatory System:

 Blood pressure: Systolic/Diastolic:

 Heart:

e. Gastrointestinal System:

 Abdomen:

 Liver:

 Spleen:

f. Central Nervous System:

 g. Other systems :

1. Laboratory Teats:

Urine examination: Specific gravity:

 Albumin:

 Sugar:

 Microscopic:

1. Report on X-ray examination of the chest:
2. 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