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](mailto:seameo@moh.gov.my) or [fasihah.amir@gmail.com](mailto: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