

# **Application Guidelines**

### In completing the attached application form, please be advised to:

- a. Carefully read your Course Information (CI) prior to completing the application form;
- b. Use a personal computer in completing the form, or handwrite in **block letters**;
- c. Fill in the form in English;
- d. Be sure to fill in every part of the form;
- e. Send the completed form to your country's KOICA Office or the Embassy of Korea stationed in your nearest country if the former is not available- together with a copy of your passport; and
- f. Be reminded that your participation may be denied if you fail to provide the required information and documents completely and on time.

### **Application Checklist**

	Items	Page No.	Check(√) if completed
a.	Filled in every item of Applicant Information	2-4	
b.	Ticked agree/disagree box for Agreement on Collection and Use Personal, Sensitive, and Unique Identifying Information	5-6	
C.	Ticked agree/disagree box for Agreement on Sexual Harassment Policy	7	
d.	Signed the <b>declaration</b> for terms and conditions	8	
e.	Signed and filled in every part of Medical Report 1	9	
f.	Had an authorized physician to complete and sign Medical Report 2	10	
g.	Had an authorized official from your government to complete and sign the <b>Nomination</b> form	11-12	
h.	Have a <b>copy of passport</b> ready for submission	-	

# This is to certify that I have completed every part of the application form to apply for the KOICA Fellowship Program.

Date: \_\_\_\_\_ Applicant's Name: \_\_\_\_\_ Signature: \_\_\_\_

## Application Form for the KOICA Fellowship Program

This form is to be used to apply for the Fellowship Program of the Korea International Cooperation Agency (KOICA), which is implemented as part of the Official Development Assistance Program of the Government of Korea. Please complete the application form

(Photo)



and consult with your respective country's KOICA Office - or the Embassy of Korea in charge of your country, if the former is not available - for further information.

### PART. 1. APPLICANT INFORMATION (to be completed by the applicant)

Program Title
Course Duration         fromto(DD-MM-YYYY)           . PERSONAL DATA           First Name           Middle Name           Middle Name           Family Name           Family Name           Date of Birth           Day         Month           Year           Sex           Ome           Mationality           Home Address           Contact           Information           (Including Country Code)           Name           Emergency           Contact (2)           Telephone           Telephone           E-mail           Contact (2)           Telephone           Telephone           Contact (2)           Telephone           Contact (2)           Telephone           Telephone           Contact (2)           Telephone           Telephone           CORACT           Telephone           Telephone           Contact (2)           Telephone           Telephone           Contact (2)           Telephone
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Present Position     Employment Duration     from       Government     □ Central □ Local
Government  □ Central □ Local
Type of     Institution     □ Public     □ Private     □ International     □ NGO       Organization     □
Others (Please specify)
Job Description Describe your main duties. Specify any technical equipment or facilities you work on with if appli
Describe any themes, topics and places of interest you would like to see in the Course related to



Elaborate on organizational setback or challenges that you wish to address through the Course.

Elaborate on your plans to apply the lessons learned from the Course to your organization.

#### VI. CAREER RECORD

# Career Background (Past 5 Years) Organization Department **Position / Responsibilities** From

### **Educational Background (Higher Education)**

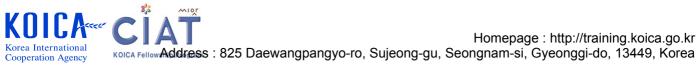
Name of Institution	City / Country	Field of Study and Degree		R
	ong / country		From	
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#### Previous Attendance to Training Program in Foreign Countries

	usly attended any con of other countries?	urses sponsored under programs of		lf yes,			
				, , , , , , , , , , , , , , , , ,			
Training Institute	City / Country	Course Title	From				
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#### V. LANGUAGE PROFICIENCY

#### Native Language : \_\_\_\_ English Excellent Good Fair Basic Remarks Listening Speaking Writing Reading Other Languages (please specify) : \_ Excellent Good Basic Remarks Fair Listening

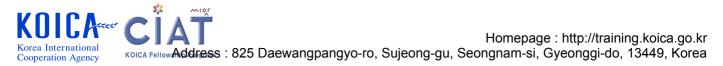


Speaking
Writing
Reading

. Excellent: Refined fluency skills and topic-controlled discussions, debates & presentations. Formulates strategies to deal with various essay types, includir 2. Good: Conversational accuracy & fluency in a wide range of situations: discussions, short presentations & interviews. Compound complex sentences. Ex 3. Fair: Broader range of language related to expressing opinions, giving advice, making suggestions. Limited compound and complex sentences & expand 4. Basic: Simple conversation level, such as self-introduction, brief question & answer using the present and past tenses.

#### . OTHERS

Restriction on	□ NO	YES >>      No Beef      No Pork      No Fish	
Food/Behavior/ Medication		□ Others( )	



## PART. 2. TERMS & CONDITIONS

Applicants should read, abide by, and respect the following terms and conditions. Failure to abide by the followings may result in dismissal from the program and report to applicant's government and /or employer.

#### I. PRIVACY & COPYRIGHT POLICY

- a. Any information used for identifying individuals that is acquired by KOICA will be stored, used and/or analyzed only within the scope of KOICA activities, and in accordance with KOICA policy and regulations.
- b. KOICA may provide and disclose the collected information aforesaid to a third party in accordance with KOICA policy and regulations, with the relevant laws of Korea, or upon the request from the Government of Korea.
- c. KOICA reserves the right to use all the documents or products produced by participants for the purpose of the Fellowship Program (e.g. country report, action plan, thesis, essay, etc.) including their duplication, translation, distribution, and/or posting on websites (KOICA website and/or other websites related to Korean ODA).
- d. KOICA takes measures required to prevent leakage, loss, or destruction of acquired information. Should you wish to inquire further about KOICA's privacy policy and personal information management, please contact the program manager via the contact information provided in your Course Information (CI), or send an email to ciat@koica.go.kr.
- e. If you do not approve of the above conditions, you may also refuse to agree. However, please be informed that there may be limitations to your participation to the KOICA Fellowship Program if you do not agree with the above conditions.

### Agreement on Collection and Use of Personal Information

- 1 KOICA collects and uses the participants' Unique Identifying Information; and is able to provide such information for a third party in accordance with KOICA policy and regulations.
  - **Personal Information Collected** : name, date of birth, sex, nationality, contact information, employment status, career and educational record
  - Purpose : implementation and promotion of the KOICA Fellowship Program, identification of participants, record keeping, supporting KOICA Club activities, and strengthening the partnership between Korea and Partner Countries
  - **Retention Period** : 3 years for hard copy / permanent preservation for soft copy
- 2 If you do not approve our collection and use of your personal information, you may also refuse to agree. However, you may have limited support from KOICA regarding visa issuance, immigration management, flight and accommodation arrangement, KOICA Club activities, insurance and medical service.

□ Agree □ Disagree

### Agreement on Collection and Use of Sensitive Information

- <sup>1</sup> KOICA collects and uses the participants' Sensitive Information; and is able to provide such information for a third party in accordance with KOICA policy and regulations.
  - Sensitive Information Collected : religion, medical information
  - Purpose : implementation and organization of the KOICA Fellowship Program in consideration of participants' religious characteristics, screening of participants' health condition to participate in KOICA Fellowship Program, insurance and medical service
  - **Retention Period** : 3 years for hard copy / permanent preservation for soft copy

<sup>2</sup> If you do not approve our collection and use of your sensitive information, you may also refuse to agree. However, you may have limited support from KOICA regarding your religious activities and requirements, insurance and medical service.

□ Agree □ Disagree

#### Agreement on Collection and Use of Unique Identifying Information

- 1 KOICA collects and uses the participants' Unique Identifying Information; and is able to provide such information for a third party in accordance with KOICA policy and regulations.
  - Unique Identifying Information Collected : passport number, alien registration number
  - **Purpose** : visa issuance, immigration management, flight and accommodation arrangement, insurance and medical service
  - **Retention Period** : 5 days after the accomplishment of the purpose specified above
- 2 If you do not approve our collection and use of your unique identifying information, you may also refuse to agree. However, you may have limited support from KOICA regarding visa issuance, immigration management, flight and accommodation arrangement, insurance and medical service.

□ Agree □ Disagree

### **II. POLICY ON SEXUAL HARASSMENT**

Korea International

Cooperation Agency

- a. Sexual harassment, defined as a form of behavior characterized by sexually connotative words, acts or gestures that could undermine individual dignity and by which the victim takes offense, is regarded as a serious misconduct and will be dealt with accordingly.
- b. Once a sexual harassment case is filed, it is proceeded either to a review with the Program Manager, or to a review by KOICA Advisory Board. Sexual harassment cases may result in serious repercussions including 1) dismissal from the Program, 2) report to the pertinent embassy and/or government, 3) civil and criminal lawsuits and penalties.
- c. Participants are encouraged to file a complaint in accordance with KOICA's complaint procedure, when they feel that they are sexually harassed.

#### Agreement on Sexual Harassment Policy

- 1 I fully understand and agree to abide by KOICA's policy on sexual harassment.
- 2 I understand the definition of sexual harassment as clarified above, and will not engage in any behavior that may be regarded as sexual harassment.
- 3 I understand that there are serious repercussions to engagement in sexual harassment cases.
- 4 I understand that I can file a complaint in accordance with KOICA's complaint procedure when I feel that I am sexually harassed.
- 5 I agree that when I am involved in civil and/or criminal lawsuits for my misconduct during the course period, KOICA has the right to acquire any information regarding the case.

□ Agree □ Disagree

#### **III. GENERAL TERMS & CONDITIONS**

#### a. Attendance & Punctuality

- 1 Participants should be on-time and professional when submitting/presenting any reports and documents requested for the KOICA Fellowship Program.
- 2 Participants should be punctual and devoted to following the schedule of the KOICA Fellowship

Program. Participants are monitored and evaluated on their professional behavior while participating in the Program. KOICA may report the monitoring and evaluation results to Participants' government and/or employer when necessary. Absence without prior notice or acceptable reasons, and habitual tardiness are subject to evaluation, and may cause disadvantages.

Participants must leave Korea upon the completion of the Fellowship Program within three calendar 3 days (seven calendar days for the Scholarship Program) unless they have obtained prior approval from KOICA and the government of their country of residence.

#### b. Misconduct

Cooperation Agency

- Any form of harassment or insult, including but not limited to misconduct arising out of racial/ethnic, 1 gender or class discrimination, whether it be physical or verbal, will not be tolerated and will be dealt with in accordance with the Korean law and KOICA policy.
- 2 Any kind of disturbance to the efficient implementation of the Fellowship Program, including a breakaway from the Program, immoderate drinking, and other arbitrary and irresponsible behavior, will not be tolerated.
- 3 Participants are obliged to report immediately to KOICA of any damage incurred as a result of, or in connection with their act.

### c. Security & Well-being

- Participants are responsible for their own personal belongings, safety, health and well-being. 1
- 2 KOICA supports participants' medical expenses for accidents or diseases up to a limit covered by the insurance.
- 3 Participants, however, should pay for deductibles; and are solely responsible for the expenses exceeding the insurance coverage.
  - × Pregnancy or treatment for any kind of chronic disease is excluded from the insurance coverage.

#### d. General Rules

- 1 Participants should abide by the terms and conditions of both KOICA and the training institute with regards to the Fellowship Program.
- 2 Participants should not bring any family members (dependants) to Korea or the country of training.
- Participants should refrain from engaging in political activities and any form of employment for profit or 3 gain during the course period.
- Participants are solely responsible for any claims, losses, damages, demands, actions, suits, and 4 costs for legal proceedings that arise from their fault, misconduct, negligence, and/or failure to abide by the terms and conditions aforesaid during the course period.

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<b>I V.</b>	DECI	AN	111	

of have read and fully agree to (name of applicant) (name of country)



the terms and conditions set forth above and declare that all the information given above is true and complete.

I will accept any penalties and consequences for failure to abide by the above terms and conditions, including dismissal from the Program and report to my government and/or employer.

Date: \_\_\_\_\_ Applicant's Name: \_\_\_\_\_ Signature: \_\_\_\_\_



# PART. 3. MEDICAL REPORTS

Present Status         Do you currently use any drugs for the treatment of a medical condition? (give name & dosage)         □ No       □ Yes >> Name of Medication ( ), Quantity ( )         Are you pregnant? (female only)       □         □ No       □ Yes >> ( months )         Please indicate any needs arising from disabilities that may require additional support or facilities.         ( )       0         ( Are Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed eccount of your condition.         Medical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Persent:       No       □ Yes >> Present condition ( )         Past:       0       0       □ Yes >> Present condition ( )         Past:       0       0       □ Yes >> Present condition ( )         Past:       0       0       □ Yes >> Present condition ( )         Present:       0       0       □ Yes >> Present condition ( )         Present:       0       0       □ Yes	Do you currently use any drugs for the treatment of a medical condition? (give name & dosage)   □ No □ Yes >> Name of Medication ( ), Quantity ( )   ∩ No □ Yes >> ( months )   Please indicate any needs arising from disabilities that may require additional support or facilities.   ( ) )   Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.   edical History   Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)   Past:   □ No   □ Yes >> Name of illness ( ), Place & dates ( )   Present:   □ No   □ Yes >> Present condition ( )   Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?   Past:   □ No   □ Yes >> Present condition ( )   High blood pressure   Past:   □ No   □ Yes   Present:   □ No   □ Yes   Present:   □ No   □ Yes   Present:   □ No   □ Yes   Past:   □ No   □ Yes   Present:   □ No   □ Yes   Past:   □ No   □ Yes   Present:   □ No   □ Yes   Present:   □ No   □ Yes   Present:   □ No   □ Yes <th><b>IEDICAL</b></th> <th>REPORT</th> <th>1 (to be</th> <th>completed by the ap</th> <th>oplicant</th> <th>)</th> <th></th> <th></th> <th></th> <th></th>	<b>IEDICAL</b>	REPORT	1 (to be	completed by the ap	oplicant	)				
No       □ Yes >> Name of Medication ( ), Quantity ( )         Are you pregnant? (female only)         □ No       □ Yes >> ( months )         Please indicate any needs arising from disabilities that may require additional support or facilities.         ( )       Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         Medical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Pest:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Present:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Present:       □ No       □ Yes >> Present condition ( )         Past:       □ No       □ Yes >> Present condition ( )         Past:       □ No       □ Yes >> Present condition ( )         Present:       □ No       □ Yes >> Present condition ( )         Past:       □ No       □ Yes >> Present condition ( )         Present:       □ No       □ Yes >> Present condition ( )         Present:       □ No       □ Yes	□ No       □ Yes >> Name of Medication (       ), Quantity (       )         Are you pregnant? (female only)										
Are you pregnant? (female only)       No       □ Yes >> (       months )         Please indicate any needs arising from disabilities that may require additional support or facilities.       (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.       Medical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)       Pesset:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Present condition (       )       Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       □ No       □ Yes >> Present condition (       )       )         High blood pressure       Past:       □ No       □ Yes         Present:       □ No       □ Yes       Present:       )         Past:       □ No       □ Yes       `       - Are you taking any medicine or insulin?       )         Past:       □ No       □ Yes       `       - Are you taking any medicine or insulin?       `       No       □ Yes         Thyroid Problem <td< td=""><td>Are you pregnant? (female only)       No       PResolution         No       □ Yes &gt;&gt; (       months)         Please indicate any needs arising from disabilities that may require additional support or facilities.         (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edital History         Have you had any significant or serious illnesses? (If hospitalized, give place &amp; dates.)         Past:       □ No       □ Yes &gt;&gt; Present condition (       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       □ No       □ Yes &gt;&gt; Present condition (       )         Present:       □ No       □ Yes &gt;&gt; Present condition (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       □ No       □ Yes         Past:       □ No       □ Yes       Present       ○ No         Present:       □ No       □ Yes       □ Present condition (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       □ No       □ Yes         Present:       □ No       □ Yes       □ Present condition (       ) mm/Hg         □ Inforcious Disease &gt;&gt; Specify the name of illness (</td><td></td><td>-</td><td></td><td></td><td>nt of a m</td><td>edical condit</td><td>ion? (giv</td><td>ve name &amp;</td><td>dosage)</td><td></td></td<>	Are you pregnant? (female only)       No       PResolution         No       □ Yes >> (       months)         Please indicate any needs arising from disabilities that may require additional support or facilities.         (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edital History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       □ No       □ Yes >> Present condition (       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       □ No       □ Yes >> Present condition (       )         Present:       □ No       □ Yes >> Present condition (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       □ No       □ Yes         Past:       □ No       □ Yes       Present       ○ No         Present:       □ No       □ Yes       □ Present condition (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       □ No       □ Yes         Present:       □ No       □ Yes       □ Present condition (       ) mm/Hg         □ Inforcious Disease >> Specify the name of illness (		-			nt of a m	edical condit	ion? (giv	ve name &	dosage)	
Im No       Im Yes >> ( months )         Please indicate any needs arising from disabilities that may require additional support or facilities.         (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         Medical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No         No       Yes >> Present condition (         Have you ever been a patient in a mental hospital or have been treated by a psychiatris?         Past:       No         No       Yes >> Present condition (         Present:       No         Yes >> Present condition (       )         High blood pressure       Persent:         Past:       No       Yes >> Present condition (         Present:       No       Yes >> Present condition (         Present:       No       Yes >> Present condition (         Present:       No       Yes         Vhat lintess(e	No       ¬Yes >> (       months )         Please indicate any needs arising from disabilities that may require additional support or facilities.       (         (       )         Nate: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No       Yes >> Present condition (         Inve you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Present condition (         Inve you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Present condition (         Present:       No       Yes >> Present condition (         Present:       No       Yes >> Present condition (         Past:       No       Yes >> Present condition (         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Otor >>       Present condition (       )         Infectious Disease >> Specify the name										
Please indicate any needs arising from disabilities that may require additional support or facilities.         (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         Wedical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No       `Yes >> Name of illness (       ), Place & dates (       )         Present:       No       `Yes >> Name of illness (       ), Place & dates (       )         Present:       No       `Yes >> Name of illness (       ), Place & dates (       )         Present:       No       `Yes >> Name of illness (       ), Place & dates (       )         Present:       No       `Yes >> Present condition (       )       )         Present:       No       `Yes >> Present condition (       ) mm/Hg         Present:       No       `Yes >> Present condition (       )         Thortiof Problem       `Liver Disease	Please indicate any needs arising from disabilities that may require additional support or facilities.         (       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       □ No       □ Yes >> Name of illness (       ). Place & dates (       )         Have you even been a patient in a mental hospital or have been treated by a psychiatrist?       Pase:       □ No       □ Yes >> Present condition (       )         Past:       □ No       □ Yes >> Present condition (       )       )         Past:       □ No       □ Yes >> Present condition (       )         Past:       □ No       □ Yes >> Present condition (       ) mm/Hg         Past:       □ No       □ Yes       Present:         Past:       □ No       □ Yes       Present         Past:       □ No       □ Yes         Present:       □ No       □ Yes         Present:       □ No       □ Yes         Prosent:       □ Present condition (       )         □ Thyroid Problem       □ Liver Disease       □ Kidney Disease										
(       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         Addical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No         No       Yes >> Name of illness (       ), Place & dates (         Past:       No       Yes >> Name of illness (       ), Place & dates (         Past:       No       Yes >> Name of illness (       ), Place & dates (         Past:       No       Yes >> Name of illness (       ), Place & dates (         Past:       No       Yes >> Name of illness (       ), Place & dates (       )         Present:       No       Yes >> Name of illness (       ), Place & dates (       )         Present:       No       Yes >> Name of illness (       ), Place & dates (       )         Present:       No       Yes       Present condition (       )       )         Present:       No       Yes       Present condition (       )       .       Are you taking any medicine or insulin?       No       Yes         Present:       No       Yes       - Are you taking any medicine or insulin?       No       Ye	(       )         Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Name of illness (       ), Place & dates (       )         Present:       □ No       □ Yes >> Present condition (       )       )         High blood pressure       Present:       □ No       □ Yes         Present:       □ No       □ Yes       □         Present:       □ No       □ Yes       □         □ No       □ Yes       □ No       □ Yes         □ Infectious Disease       □ Asthma       □ Stomach and Intestinal Disorder       □         □ Infectious Disease       □ Asthma       □ Stomach and Intestinal Disorder       □         □ Infectious Diseases() been cured?       □       □ <td colspan="5"></td> <td></td> <td></td>										
be directly inquired by the KOICA Program Manager for more detailed account of your condition.         Addical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Name of illness ( ), Place & dates ( )         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Past:       No       Yes >> Present condition ( )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Present condition ( )         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Present:       No         Past:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       -       Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       -       -         Past:       No       Yes         Present:       No       Yes         Inforcious Disease >> present condition ( )       -         Interculosis       -       Astima         Tube	be directly inquired by the KOICA Program Manager for more detailed account of your condition.         edical History         Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Present:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Present:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Past:       □ No       □ Yes >> Present condition ( )         Past:       □ No       □ Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Pist:       □ No       □ Yes         Present:       □ No       □ Yes         □ Thyroid Problem       □ Liver Disease       □ Kidney Disease         □ Theroid Disease >> Specify the name of illness ( )       )       )         □ Theresent:       □ No       □ Yes         □ Thyroid Problem       □ Liver Disease       □ Kidney Disease         □ Thereotus Disease >> Specify the name of illness ( )       )       )         □ Others >> Specify the name of illness ( )       )       )         □ Specify the n	Please in	dicate any	/ needs	arising from disabiliti	es that	may require a	additiona	al support o	or facilities.	_
Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         High blood pressure       -         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       -         Past:       No       Yes         Present:       No       Yes         Infectious Disease >> Specify the name of illness ( )       )	Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       □ No       □ Yes >> Name of illness ( ), Place & dates ( )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       □ No       □ Yes >> Present condition ( ), Place & dates ( )         Present:       □ No       □ Yes >> Present condition ( ), Place & dates ( )         Present:       □ No       □ Yes >> Present condition ( ), Place & dates ( )         Present:       □ No       □ Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       □ No       □ Yes         Present:       □ No       □ Yes										
Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         No       Yes >> Present condition ( )       )         High blood pressure       Present:       No         Past:       No       Yes >> Present condition ( )       )         High blood pressure       Present:       No       Yes >> Present condition ( )         Past:       No       Yes >> Present condition ( )       )         Past:       No       Yes         Present:       No       Yes         Present:       - Present condition ( )       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       No       Yes         Uhat problem       Liver Disease       Borach and Intestinal Disorder         Infectious Disease >> Specify the name of illness ( )       )       )         Others >> Specify ( </td <td>Have you had any significant or serious illnesses? (If hospitalized, give place &amp; dates.)   Past: □ No   □ Yes &gt;&gt; Name of illness ( ), Place &amp; dates ( )   Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?   Past: □ No   □ Yes &gt;&gt; Name of illness ( ), Place &amp; dates ( )   Present: □ No   □ Yes &gt;&gt; Name of illness ( ), Place &amp; dates ( )   Present: □ No   □ Yes &gt;&gt; Present condition ( )   Past: □ No   □ Yes &gt;&gt; Present condition ( )   Past: □ No   □ No □ Yes &gt;&gt; Present condition ( )   Pige source   Past: □ No   □ No □ Yes &gt;&gt; Present condition ( )   Pisters □ No   □ No □ Yes   Present: □ No   □ No □ Yes   Present: □ No   □ Yes □ Present condition ( )   Provide Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Others &gt;&gt; Specify the name of illness ( )   • Present condition ( )   I certify that I have answered all questions truthfully a</td> <td>Aedical Hig</td> <td>story</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)   Past: □ No   □ Yes >> Name of illness ( ), Place & dates ( )   Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?   Past: □ No   □ Yes >> Name of illness ( ), Place & dates ( )   Present: □ No   □ Yes >> Name of illness ( ), Place & dates ( )   Present: □ No   □ Yes >> Present condition ( )   Past: □ No   □ Yes >> Present condition ( )   Past: □ No   □ No □ Yes >> Present condition ( )   Pige source   Past: □ No   □ No □ Yes >> Present condition ( )   Pisters □ No   □ No □ Yes   Present: □ No   □ No □ Yes   Present: □ No   □ Yes □ Present condition ( )   Provide Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Thyroid Problem □ Liver Disease   □ Others >> Specify the name of illness ( )   • Present condition ( )   I certify that I have answered all questions truthfully a	Aedical Hig	story								
Past:       No       Yes >> Name of illness (       ), Place & dates (       )         Present:       No       Yes >> Present condition (       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Name of illness (       ), Place & dates (       )         Present:       No       Yes >> Present condition (       )       )         High blood pressure       Past:       No       Yes >> Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)       Peset:       No       Yes       Present:       No       Yes         Present:       No       Yes       Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)       Pest:       No       Yes         Past:       No       Yes       Present:       No       Yes         Infectious Disease (sugar on the urine)       Pesetify the one of illness (       )       )       )         Infectious Disease >> Specify the name of illness (       )       )       )       )         Infectious Disease >> Specify the name of illness (       )       )       )       )         Infectious Disease >> Specify the name of illness (	Past:       INO       IVes >> Name of illness (       ), Place & dates (       )         Present:       INO       IVes >> Present condition (       )       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?       Past:       INO       IVes >> Present condition (       )         Present:       INO       IVes >> Present condition (       )       )       )         High blood pressure       Present:       INO       IVes >> Present condition (       )       )         Past:       INO       IVes >> Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       INO       IVes         Present:       INO       IVes		•	sianifica	nt or serious illnesse	es? (If ho	ospitalized, g	ive place	e & dates.)		
Present:       No       Yes >> Present condition (       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?       Past:       No       Yes >> Name of illness (       ), Place & dates (       )         Past:       No       Yes >> Present condition (       )       )       High blood pressure         Past:       No       Yes >> Present condition (       )       )       )         Present:       No       Yes >> Present condition (       )       )       )         Present:       No       Yes >> Present condition (       )       )       )         Diabetes (sugar in the urine)       Present:       No       Yes         Present:       No       Yes        )       - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?        No       Yes       No       Yes         Interclous Disease >> Specify the name of illness (       )       )       )       O there >>       Secify the name of illness	Present:       INO       Yes >> Present condition (       )         Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       INO       Yes >> Present condition (       )         Present:       INO       Yes >> Present condition (       )         High blood pressure       INO       Yes >> Present condition (       )         Past:       INO       Yes >> Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)       Yes       Infections (       )       .         Past:       INO       Yes       .       .       .       .         Present:       INO       Yes       .       .       .       .         Present:       INO       Yes       .       .       .       .         Present:       INO       Yes       .       .       .       .       .       .       .         Present:       INO       Yes       .       .       .       .       .       .       .       Yes       .       .       .       .       .       .       .       Yes       .       .       .       .       .       .       .       .										
Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         High blood pressure       Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg       )         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) )          Present:       -       -         Thyroid Problem       Liver Disease   Heart Disease   Kidney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder         Infectious Disease >> Specify the name of illness ( )         )         Has the above illness(es) been cured?       )         Yes       No       Sect	Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?         Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       No       Yes         Present:       No       Yes       Present:       Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes       Present:       Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes       Present:       Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes       Present condition ( ) Res       Present condition ( ) Res         Present:       -       Present condition ( ) Res       Present condition ( ) Res       Present condition ( ) Res         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease       Ridney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder       Present condition ( )       Present condition ( )         Infectious Disease >> Specify the name of illness ( )       Present condition ( )       Pres				`		), 1 10.00			· · ·	$\neg$
Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg       ) mm/Hg         Past:       No       Yes >>         Present:       -       Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       -         Past:       No       Yes         Present:       -       -         -       Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       -         Past:       No       Yes         Present:       -       -         -       No       Yes         What illness(es) have you had previously?       -         -       Thyroid Problem       -         -       Iver Disease       -       Heart Disease         -       No       -       Stomach and Intestinal Disorder         -       Infectious Disease >> Specify the name of illness ( ) )       - <td>Past:       No       Yes &gt;&gt; Name of illness ( ), Place &amp; dates ( )         Present:       No       Yes &gt;&gt; Present condition ( )         Past:       No       Yes &gt;&gt; Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       -       Present condition ( )       )       -       Yes         What illness(es) have you had previously?       -       No       Yes       Yes         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Infectious Disease &gt;&gt; Specify the name of illness ( )       )       -       -         Infectious Disease &gt;&gt; Specify the name of illness ( )       )       -       -         Yes       No       - Specify the name of illness ( )       -       -         Infectious Disease       &gt; Specify the name of illness ( )       -       -         Yes       No       - Specify the name of illness ( )       -       -</td> <td></td> <td>_</td> <td></td> <td></td> <td>·</td> <td>ave been tree</td> <td>atod by</td> <td>- novohiotri</td> <td>/</td> <td></td>	Past:       No       Yes >> Name of illness ( ), Place & dates ( )         Present:       No       Yes >> Present condition ( )         Past:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)       Past:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       No       Yes       Present:       No       Yes         Present:       -       Present condition ( )       )       -       Yes         What illness(es) have you had previously?       -       No       Yes       Yes         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Infectious Disease >> Specify the name of illness ( )       )       -       -         Infectious Disease >> Specify the name of illness ( )       )       -       -         Yes       No       - Specify the name of illness ( )       -       -         Infectious Disease       > Specify the name of illness ( )       -       -         Yes       No       - Specify the name of illness ( )       -       -		_			·	ave been tree	atod by	- novohiotri	/	
Present:       No       Yes >> Present condition (       )         High blood pressure       Past:       No       Yes >> Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)       Past:       No       Yes >> Present condition (       )       )         Past:       No       Yes >> Present condition (       )       )       )       )         Past:       No       Yes >> Present condition (       )       )       )       )         Past:       No       Yes >       >       No       Yes >         Present:       -       -       Present condition (       )       )         -       Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       -       Heart Disease       Kidney Disease         -       Tuberculosis       -       Asthma       Stomach and Intestinal Disorder         -       Infectious Disease >>       Specify the name of illness (       )       )       )         -       Others >>       Specify the name of illness (       )       .       )       .         -       Present condition (       )       .       .       .       .       . </td <td>Present:       No       Yes &gt;&gt; Present condition (       )         High blood pressure         Past:       No       Yes &gt;&gt; Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       - Present condition (       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - Are you taking any medicine or insulin?       No       Yes         Tuberculosis       - Asthma       - Stomach and Intestinal Disorder       -         Infectious Disease       &gt; Specify the name of illness (       )       -         Others       &gt; Specify (       )       -         Has the above illness(es) been cured?      </td> <td></td> <td></td> <td>· ·</td> <td>•</td> <td></td> <td></td> <td>-</td> <td></td> <td>\ \</td> <td></td>	Present:       No       Yes >> Present condition (       )         High blood pressure         Past:       No       Yes >> Present condition (       ) mm/Hg to (       ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       - Present condition (       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - Are you taking any medicine or insulin?       No       Yes         Tuberculosis       - Asthma       - Stomach and Intestinal Disorder       -         Infectious Disease       > Specify the name of illness (       )       -         Others       > Specify (       )       -         Has the above illness(es) been cured?			· ·	•			-		\ \	
High blood pressure         Past:       No       Yes         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         Present:       -       -         No       Yes         Present:       -       -         -       Are you taking any medicine or insulin?       No         -       Are you taking any medicine or insulin?       No         -       Are you taking any medicine or insulin?       No         -       Are you taking any medicine or insulin?       No         -       Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       -       Heart Disease       Kidney Disease         -       Tuberculosis       Asthma       Stomach and Intestinal Disorder       -         -       Infectious Disease       >> Specify the name of illness (       )       -         -       Others >> Specify the name of illness (       )       -       Present condition (       )         -       Present condition (       )       -       Present condition (       ) </td <td>High blood pressure         Past:       No       Yes         Present:       No       Yes &gt;&gt; Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       - Present condition ( )       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - Are you taking any medicine or insulin?       No       Yes         Thyroid Problem       □ Liver Disease       □ Heart Disease       □ Kidney Disease         □ Tuberculosis       □ Asthma       □ Stomach and Intestinal Disorder         □ Infectious Disease &gt;&gt; Specify the name of illness ( )       )         □ Others &gt;&gt; Specify the name of illness ( )       )         Has the above illness(es) been cured?       )         Present condition ( )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:      </td> <td></td> <td></td> <td></td> <td>•</td> <td></td> <td>), Place</td> <td>&amp; dates</td> <td>; (</td> <td>)</td> <td>_</td>	High blood pressure         Past:       No       Yes         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       No       Yes         Present:       - Present condition ( )       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - Are you taking any medicine or insulin?       No       Yes         Thyroid Problem       □ Liver Disease       □ Heart Disease       □ Kidney Disease         □ Tuberculosis       □ Asthma       □ Stomach and Intestinal Disorder         □ Infectious Disease >> Specify the name of illness ( )       )         □ Others >> Specify the name of illness ( )       )         Has the above illness(es) been cured?       )         Present condition ( )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:				•		), Place	& dates	; (	)	_
Past:       No       Yes         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       -       No       Yes         Present:       -       Present condition ( )       )         -       Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       -       No       Yes         •       Thyroid Problem       Liver Disease       •       Heart Disease       •         •       Thyroid Problem       Liver Disease       •       Heart Disease       •       Kidney Disease         •       Thyroid Problem       Liver Disease       •       Heart Disease       •       Kidney Disease         •       Tuberculosis       •       Asthma       •       Stomach and Intestinal Disorder         •       Infectious Disease >> Specify the name of illness ( )       )       •       )       •         •       No       -       Specify the name of illness ( )       )       •       .         •       Present condition ( )       •       Present condition ( )       )       .         <	Past:       No       Yes         Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       No       Yes         -       - Present condition ( )       )         -       - Present condition ( )       )         -       - Present condition ( )       )         -       - Are you taking any medicine or insulin?       No         -       Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       -       -       Kidney Disease         -       Tuberculosis       -       Asthma       -       Stomach and Intestinal Disorder         -       Infectious Disease       >>       Specify the name of illness ( )       )       -         -       Others       >>       Specify the name of illness ( )       )       -       Present condition ( )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.       -       ter:				>> Present condition	I (				)	
Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       - Present condition ( ) - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       No       Yes         Information Problem       I Liver Disease       Heart Disease       Kidney Disease         Information Specify the name of illness ( )       )       )       Heart Disease       )         Others       >> Specify the name of illness ( )       )       )       Heart Disease       )         Others       >> Specify the name of illness ( )       )       )       )       Heart Disease         Yes       No       - Specify the name of illness ( )       )       )       )         Has the above illness(es) been cured?       )       .       Present condition ( )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.       .         ate:	Present:       No       Yes >> Present condition ( ) mm/Hg to ( ) mm/Hg         Diabetes (sugar in the urine)         Past:       No       Yes         Present:       - Present condition ( ) - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - Are you taking any medicine or insulin?       No       Yes         Thyroid Problem       - Liver Disease       - Heart Disease       - Kidney Disease         - Tuberculosis       - Asthma       - Stomach and Intestinal Disorder         - Infectious Disease       -> Specify the name of illness ( )       )         - Others >> Specify the name of illness ( )       )         - Present condition ( )       )         Has the above illness(es) been cured?       )         Yes       No       - Specify the name of illness ( )         - Present condition ( )       )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:		· ·								
Diabetes (sugar in the urine)         Past:       No         Past:       No         Present:       - Present condition (         - Are you taking any medicine or insulin?       No         Present:       - Are you taking any medicine or insulin?         Interculosis       - Are you taking any medicine or insulin?         Interculosis       - Are you taking any medicine or insulin?         Infectious Disease       - Heart Disease         Infectious Disease       > Specify the name of illness (         Infectious Disease       > Specify the name of illness (         Others       > Specify the name of illness (         Others       > Specify the name of illness (         Present condition (       )         Intertify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:	Diabetes (sugar in the urine)         Past:       No       Yes         Present:       - Present condition (       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - No       Yes         - Thyroid Problem       - Liver Disease       - Heart Disease       - Kidney Disease         - Tuberculosis       - Asthma       - Stomach and Intestinal Disorder         - Infectious Disease >> Specify the name of illness (       )       )         - Others >> Specify (       )         Has the above illness(es) been cured?       )         Yes       No       - Specify the name of illness (       )         - Present condition (       )       )       .         Yes       No       - Specify the name of illness (       )         - Present condition (       )       .       .         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:       Applicant's Name:       Signature:         IEDICAL REPORT 2 (to be completed by an authorized physician)       .         asic Health Information       Name         Age       Blood Type       Height         Sex       Blood Pressure /	Past:	□ No	□ Yes							
Past:       No       Yes         Present:       No       Yes         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       No       Yes         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder         Infectious Disease >> Specify the name of illness (       )         Others >> Specify (       )         Has the above illness(es) been cured?         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:       Applicant's Name:       Signature:         MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information       Name         Age       Blood Type       Height         Sex       Blood Pressure / mmHG       Weight	Past:       No       Yes         Present:       No       Yes         - Present condition (       )         - Are you taking any medicine or insulin?       No         What illness(es) have you had previously?         Thyroid Problem       Liver Disease         - Tuberculosis       - Astma         - Infectious Disease       -> Specify the name of illness (         - Others >> Specify (       )         - Specify the name of illness (       )         - Present condition (       )         - Specify the name of illness (       )         - Present condition (       )         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:	Present:	🗆 No	□ Yes	>> Present condition	I (	) mm/Hg to	) (	) mm/H	g	
Present:       No       Yes       .         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       No       Yes         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder         Infectious Disease       Asthma       Stomach and Intestinal Disorder         Infectious Disease       Specify the name of illness (       )         Others       Specify (       )         Has the above illness(es) been cured?       )       .         Yes       No       .       .         Yes       No       .       .         It certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:        Signature:          Applicant's Name:          MEDICAL REPORT 2 (to be completed by an authorized physician)       Basic Health Information         Name        Blood Type       Height         Age       Blood Pressure       / mmHG       Weight	Present:       No       Yes       . Present condition (       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         - Infectious Disease >> Specify the name of illness (       )       )         - Others >> Specify (       )       )         Has the above illness(es) been cured?       )         Yes       O       - Specify the name of illness (       )         - Specify the name of illness (       )       )         Has the above illness(es) been cured?       )       )         Yes       O       - Specify the name of illness (       )         - Present condition (       )       )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:	Diabetes	(sugar in	the urin	e)						
Present:       - Present condition (       )         - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?       - No       Yes         Introduction Problem       I Liver Disease       Heart Disease       Kidney Disease         Introduction Interviously       - Stomach and Intestinal Disorder       )         Infectious Disease       Asthma       Stomach and Intestinal Disorder         Infectious Disease       Specify the name of illness (       )         Others       Specify the name of illness (       )         Others       Specify the name of illness (       )         Present condition (       )       )         Has the above illness(es) been cured?       )         Yes       No       - Specify the name of illness (         - Present condition (       )       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:	Present:       - Present condition ( )       - Are you taking any medicine or insulin?       No       Yes         What illness(es) have you had previously?         Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder         Infectious Disease >> Specify the name of illness ( )       )         Others >> Specify ( )       )         Has the above illness(es) been cured?         Yes       No         - Specify the name of illness ( )         - Present condition ( )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:       Applicant's Name:       Signature:         Mame          Age       Blood Type       Height         Sex       Blood Type       Height         Sex       Blood Type       Height	Past:									
□ Thyroid Problem       □ Liver Disease       □ Heart Disease       □ Kidney Disease         □ Tuberculosis       □ Asthma       □ Stomach and Intestinal Disorder         □ Infectious Disease >> Specify the name of illness (       )         □ Others >> Specify (       )         Has the above illness(es) been cured?       )         □ Yes       □ No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:          MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information         Name         Age       Blood Type         Blood Pressure       / mmHG         Weight	Thyroid Problem       Liver Disease       Heart Disease       Kidney Disease         Tuberculosis       Asthma       Stomach and Intestinal Disorder         Infectious Disease >> Specify the name of illness (       )         Others >> Specify (       )         Has the above illness(es) been cured?       )         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:       Applicant's Name:         Signature:	Present:	□ No	- Pi		dicine o	r insulin?	□ No	) □ Yes		
Image: Tuberculosis       Image: Asthma       Image: Stomach and Intestinal Disorder         Infectious Disease >> Specify the name of illness (       )         Image: Others >> Specify (       )         Has the above illness(es) been cured?       )         Has the above illness(es) been cured?       )         Yes       No         - Specify the name of illness (       )         - Present condition (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:       Applicant's Name:       Signature:         MEDICAL REPORT 2 (to be completed by an authorized physician)       Basic Health Information         Name	□ Tuberculosis       □ Asthma       □ Stomach and Intestinal Disorder         □ Infectious Disease >> Specify the name of illness (       )         □ Others >> Specify (       )         Has the above illness(es) been cured?       )         □ Yes       □ No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:       Applicant's Name:       Signature:         IEDICAL REPORT 2 (to be completed by an authorized physician)         asic Health Information         Name	What illne	ess(es) ha	ve you	had previously?						
Infectious Disease >> Specify the name of illness (       )         Others >> Specify (       )         Has the above illness(es) been cured?       )         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:          Applicant's Name:          Signature:          MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information         Name         Age       Blood Type         Height         Sex       Blood Pressure         Health Examination Result	Infectious Disease >> Specify the name of illness (   Others >> Specify (   Has the above illness(es) been cured?   Yes   No   - Specify the name of illness (   - Present condition (   )   I certify that I have answered all questions truthfully and completely to the best of my knowledge.   te:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Signature:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Applicant's Name:   Signature:   Age   Blood Type   Height   Sex   Blood Pressure   Height	🗆 Thyroi	d Problem	า	Liver Disease	_ □ H	eart Disease		Kidney	Disease	
Others >> Specify (       )         Has the above illness(es) been cured?       )         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:	□ Others >> Specify (       )         Has the above illness(es) been cured?       )         □ Yes       □ No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:	Tubero	culosis		Asthma	□ S	tomach and I	ntestina	I Disorder		
Has the above illness(es) been cured?         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         Ite:       Applicant's Name:         Signature:       Signature:         MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information         Name         Age       Blood Type         Blood Pressure       / mmHG         Weight	Has the above illness(es) been cured?         Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:		ous Disea	se >>	Specify the name of i	illness (				)	
Yes       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:          Applicant's Name:          Signature:          MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information         Name         Age       Blood Type         Blood Pressure       / mmHG         Weight	Pres       No         - Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         te:			• •					)		
- Specify the name of illness (       )         - Present condition (       )         I certify that I have answered all questions truthfully and completely to the best of my knowledge.         ate:	Specify the name of illness (     Present condition (     )	Has the a	bove illne	ss(es) b	een cured?						
ate: Signature:   MEDICAL REPORT 2 (to be completed by an authorized physician)   Basic Health Information   Name   Age   Blood Type   Height   Sex   Blood Pressure   / mmHG   Weight	te: Applicant's Name: Signature: TEDICAL REPORT 2 (to be completed by an authorized physician) asic Health Information Name Age Blood Type Height Sex Blood Pressure / mmHG Weight ealth Examination Result	- Specify the name of illness ( )									
MEDICAL REPORT 2 (to be completed by an authorized physician)         Basic Health Information         Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight	MEDICAL REPORT 2 (to be completed by an authorized physician)         asic Health Information         Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight         ealth Examination Result	I certify	that I hav	e answ	ered all questions tru	uthfully	and complet	tely to tl	he best of i	my knowledge	
Basic Health Information         Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight         Health Examination Result       Examination Result       Examination Result	asic Health Information         Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight         ealth Examination Result	ite:	App	licant's	Name:		Signatu	ire:			
Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight         Health Examination Result	Name       Height         Age       Blood Type       Height         Sex       Blood Pressure       / mmHG       Weight         ealth Examination Result				e completed by an au	uthorize	d physician)				
Age     Blood Type     Height       Sex     Blood Pressure     / mmHG     Weight	Age     Blood Type     Height       Sex     Blood Pressure     / mmHG     Weight		ith Inforn	nation							
Sex     Blood Pressure     / mmHG     Weight       Health Examination Result     Image: Sex of the second sec	Sex     Blood Pressure     / mmHG     Weight       ealth Examination Result							<u> </u>			
Health Examination Result	ealth Examination Result	-							-		
		Sex			Blood Pressure	/ n	nmHG	W	eight		
Name Result Remarks	Name Result Remarks	lealth Exa	amination	ı Resul							
		Name			Result				Remarks		



Homepage : http://training.koica.go.kr KOICA FellowAddress : 825 Daewangpangyo-ro, Sujeong-gu, Seongnam-si, Gyeonggi-do, 13449, Korea

EKG	Normal	Abnormal			
Chest PA	Normal	Abnormal			
Urinalysis	Normal	Abnormal			
Diabetes	Normal	Abnormal			
Hepatitis B	Normal	Abnormal			
Syphilis	Normal	Abnormal			
AIDS	Normal	Abnormal			
Infectious disease	Normal	Abnormal			
Endemic disease	Normal	Abnormal			
Pregnancy test	Normal	Abnormal			
<ul> <li>Less than 6 months    More than a year    More than 5 years    More than 10 years</li> <li>4. Has this person received any medical treatment for the last 5 years?</li> <li>Yes    No    Yes    Present condition (</li></ul>					
home? □ Yes □ No - \$		(	)		
I certify that I have answered all questions truthfully and completely to the best of my knowledge.					
Date : Contact Information of Clinic :					
Name of Clinic : Address of Clinic :					
Name of Physician : Signature :					



# PART. 4. NOMINATION (to be completed by nominating government / organization)

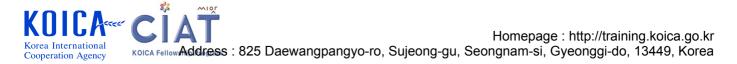
#### I. Reasons for Nomination

e.g.) relevance of the Course to the applicant's duties; applicant's capabilities of developing the institutional capacity of the organization, etc.

II. Please attach ORGANIZATION CHART with an appropriate marking of the nominee's position

III. OF	FICAL I	<b>NOMIN</b>	ATION
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The Government of	officially nomin	ates	
	(Name of Country)	(Full Name of Nominee)	
to participate in	as organized (Title of Course)	by the Korean Government(KOIC	A)
, and I, , (Name of Authorized C	on behalf of the Governme micial)	nt of, certify that (Name of Country)	



- (a) All information including career and educational background quoted by the nominee in this form is true, complete and accurate to the best of my belief and knowledge.
- (b) The nominee has an adequate knowledge of and/or expertise in the training field and has a sufficient proficiency of the language required, both spoken and written, to undergo the Course.
- (c) On behalf of the organization I agree to the terms and conditions of KOICA.
- (d) My organization shall be responsible for dealing with claims by KOICA and third parties where the loss or damage to their property, or death or personal injury was caused by gross negligence or willful misconduct of the Nominee during the participation to the KOICA Fellowship Program.
- (e) Nominee's unsatisfactory performance or failure to conform to the code of conduct may lead to limited opportunities for the organization's nomination to the KOICA Fellowship Program.

Name(Authorized Official) :		_
Position/Title:	Organization:	
Telephone:	Email:	
	Date:	Signature: