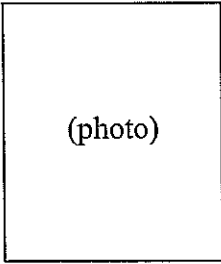


APPLICATION FORM FOR KOICA TRAINING



Korea International Cooperation Agency



HQ & ICC I : 825 Daewang pangyo-ro, Sujeong-gu, Seongnam-si, Gyeonggi-do, Korea
 Tel: 82-31-740-0114 Fax: 82-31-740-0655 E-mail: training@koica.go.kr http://www.koica.go.kr

I . TITLE OF COURSE					
II . PERSONAL DATA					
Full Name: _____					
First		Middle		Last (Surname)	
Date of Birth			Sex	Marital Status	Nationality
Month	Day	Year			
			<input type="checkbox"/> M <input type="checkbox"/> F		
Passport Number			Airport of Departure		
Home Address : _____					
Tel No : _____		Fax No : _____			
country code	area code	number	country code	area code	number
Mobile No : _____			E-mail Address: _____		
Emergency Contact – Name :			Tel No :		
III. EMPLOYMENT and EDUCATION					
Present Position/ Title: _____					
Department or Division: _____					
Name of Organization: _____					
Address: _____					
Tel No: _____		Fax No : _____			
country code	area code	number	country code	area code	number
Type of Organization: <input type="checkbox"/> Governmental/Public <input type="checkbox"/> Private <input type="checkbox"/> International <input type="checkbox"/> Other					
Term of Employment: from _____ to present					
Describe your present duties:					
Describe your expectation from this training course :					

Note: Please TYPE or PRINT clearly in CAPITAL LETTERS and prepare three (3) copies including the original. The words "NIL" or "N/A" should be used where applicable. Do not leave any space blank.

Career over past 5 years			
Name of Organization	From	To	Position/ Responsibilities
	month/year	month/year	
	/	/	
	/	/	
	/	/	

Education and Training			
Name of Institution	From	To	Field of Study and Degree
	month/year	month/year	
	/	/	
	/	/	
	/	/	

Former Training in Korea or KOICA (if any): Yes No

Program: _____ Period: _____ / _____ - _____ / _____
month/year month/year

IV. LANGUAGE PROFICIENCY
 English:

	Excellent	Good	Fair	Poor	Remarks
Listening					
Speaking					
Writing					
Reading					

Mother Tongue : _____

Other Languages : _____

In case you speak English as a foreign language, it is required for you to certify your English proficiency. Please indicate any of your English Proficiency Tests:

TOEFL: _____ TOEIC: _____ Others: _____
score score score

V. MEDICAL REPORT 1 (to be completed by an authorized physician)			
Name of Applicant: _____			
Age: _____	Sex: _____	Height: _____ cm	Weight: _____ kg
Blood Type: _____		Blood Pressure: _____ / _____ mmHg	
EKG	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Chest PA	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Urinalysis	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Diabetes	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Hepatitis B	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Hepatitis C	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Syphilis	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
AIDS	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Infectious disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Endemic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pregnancy test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
<p>1. If the applicant has a history of illness or disorders during the last 5 years, please describe the treatment and present status.</p> <p>_____</p> <p>_____</p>			
<p>2. What opinions do you have about the overall health condition of the applicant to carry out an intensive training course away from his/her home?</p> <p>_____</p> <p>_____</p>			
<p>Name of Clinic: _____</p> <p>Address of Clinic: _____</p> <p>Name of Physician: _____</p>			
<p>Date: _____ Signature of Physician: _____</p>			

MEDICAL REPORT 2 (to be completed by an applicant)

1. Present Status

(a) Do you currently use any drugs for the treatment of a medical condition? (Give name & dosage.)

No
 Yes >> Name of Medication (_____), Quantity (_____)

(b) Are you pregnant?(Female only)

No(_____), Yes (_____ months)

(c) Are you allergic to any medication or food?

No,
 Yes >>> (_____) Medication, (_____) Food, (_____) Other:

(d) Please indicate any needs arising from disabilities that might necessitate additional support or facilities.

(_____)
 Note: Disability does not lead to exclusion of persons with disability from the program. However, upon the situation, you may be directly inquired by the KOICA official in charge for a more detailed account of your condition.

2. Medical History

(a) Have you had any significant or serious illness? (If hospitalized, give place & dates.)

Past:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Name of illness (_____), Place & dates (_____)
Present:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Present Condition (_____)

(b) Have you ever been a patient in a mental hospital or been treated by a psychiatrist?

Past:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Name of illness (_____), Place & dates (_____)
Present:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Present Condition (_____)

(c) High blood pressure

Past:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Present:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Present Condition (_____) mm/Hg to (_____) mm/Hg

(d) Diabetes (sugar in the urine)

Past:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Present:	<input type="checkbox"/> No	<input type="checkbox"/> Yes>>Present Condition (_____)
Present:	<input type="checkbox"/> No	Are you taking any medicine or insulin? <input type="checkbox"/> No <input type="checkbox"/> Yes

(e-1) Past History: What illness(es) have you had previously?

<input type="checkbox"/> Stomach and Intestinal Disorder	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid Problem	
<input type="checkbox"/> Infectious Disease >>> Specify name of illness (_____)			
<input type="checkbox"/> Other >>> Specify (_____)			

(e-2) Has this disease been cured?

<input type="checkbox"/> Yes	<input type="checkbox"/> No (Specify name of illness) : _____
<input type="checkbox"/> Yes	Present Condition: (_____)

3. Other: Any restrictions on food and behavior due to health or religious reasons?

(_____)

I certify that I have read the above instructions and answered all questions truthfully and completely to the best of my knowledge. I understand and accept that medical conditions resulting from an undisclosed pre-existing condition may not be financially compensated by KOICA and may result in termination of the program.

Date: _____ Signature of Applicant: _____

VI. APPLICANT'S RESPONSIBILITIES

If accepted as a participant, I agree:

- 1) to follow the training program to the best of my ability and abide by the rules of the training institution, university, or college in which I undertake training;
- 2) to refrain from engaging in political activities, or any form of employment for profit or gain;
- 3) to return to my home country upon completion of my training program and to resume work in my country;
- 4) not to extend the length of my training or my stay for personal conveniences;
- 5) not to bring any family members (dependents) to Korea or country of training;
- 6) to accept that the Korean Government is not liable for any damage or loss of my personal property; and
- 7) to accept that the Korean Government will not assume any responsibility for illness, injury, or death arising from extracurricular activities, willful misconduct, or undisclosed pre-existing medical conditions; and
- 8) to carry out such instructions and abide by such conditions as may be stipulated by the Korean Government in respect of my training program.

I fully understand that my status as a participant may be terminated if I fail to make satisfactory progress, or for any other cause as determined by the Government of the Republic of Korea.

Applicant's Name: _____ **Signature:** _____

VII. OFFICIAL NOMINATION

The Government of _____ officially nominates
(Name of Country)
_____ for participation in _____
(Full Name of Applicant) (Name of Training Course)

as organized by the Korean Government, and certifies that:

- 1) all information supplied by the applicant is complete and correct;
- 2) the applicant has an adequate knowledge of and/ or expertise in the training field; and
- 3) the applicant has a sufficient proficiency of spoken and written English to enable him/her to follow the training course.

Name of Organization: _____

Position/ Title: _____

Name of Authorized Official: _____

Date: _____ **Signature:** _____