Version 20150803

Guidelines of Application Form for the Practical and Technical Training Course on "Occupational Hygiene and Safety"

The attached form is to be used to apply for the training programs of the OIC Occupational Safety and Health Network (OIC-OSHNET). Please complete the application form while referring to the following information.

1. How to complete the Application Form

In completing the application form, please be advised to:

a. Use a computer in completing the form.

b. Fill in the form in English.

c. Attach a picture of the Nominee.

2. Privacy Policy

Any information used for identifying individuals that is acquired by OIC-OSHNET will be stored, used, or analyzed only within the scope of OIC-OSHNET activities. OIC-OSHNET reserves the right to use such identifying information and other materials in accordance with the provisions of this privacy policy.

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Application Form for the OIC-OSHNET Training Program

Information on the Applying Organization

1. Profile of Organization

1) Name of Organization

2) The mission of the Organization and the Department / Division

2. Purpose of Application

1) Current Issues: Describe the reasons for your organization claiming the need to participate in the training program, with reference to issues or problems to be addressed.

2) Objective: Describe what your organization intends to achieve by participating in the training program.

3) **Future Plan of Actions:** Describe how your organization shall make use of the expected achievements, in addressing the said issues or problems.

4) **Selection of the Nominee:** Describe the reason(s) the nominee has been selected for the said purpose, referring to the following view points; 1) Course requirement, 2) Capacity/Position, 3) Plans for the candidate after the training program, 4) Plan of organization and 5) Others.

Information about the Nominee

1. Personal Data

Surname:							Attach the nominee's photograph
First Name:							
Gender:	**Male** ☐			**Female** ☐			
Nationality:							
Date of birth:	**Day**		**Month**		**Year**		

Contact Information

Office	Address:	
	Tel:	Mobile (Cell Phone):
	E-mail:	
Home	Address:	
	Tel:	Mobile (Cell Phone):
	E-mail:	
Contact person in emergency	Name:	
	Relationship to you:	
	Address:	
	Tel:	Mobile (Cell Phone):
	E-mail:	

Type of the Organization

	National Governmental		Local Governmental		Public Enterprise
	Private (profit)		NGO/Private (Non-profit)		University
	Other				

Educational Record

Institution	City/ Country	Period		Degree obtained	Major
		From Month/Year	To Month/Year		

Job Record

Organization	City/ Country	Period		Position or Title	Brief Job Description
		From Month/Year	To Month/Year		

Outline of Duties: Description of your work including your responsibility.

Training or Study in Foreign Countries

Institution	City/ Country	Period		Field of Study / Program Title
		From Month/Year	To Month/Year	

2. Expectation on the Applied Training Program

1) Personal Goal: Describe what you intend to achieve in the applied training program in relation to the organizational purpose.

2) Relevant Experience: Describe your previous vocational experiences which are highly relevant in the themes of the applied training program.

3) Area of Interest: Describe your subject of particular interest with reference to the contents of the applied training program.

4) Have you participated in similar training program before? Yes ☐ No ☐

Name of program	Organizer	Year

3. Declaration

I certify that the statements I made in this form are true and correct to the best of my knowledge.

If accepted for the program, I agree:

a) To submit/present any report which may be required,

b) to carry out such instructions and abide by such conditions as may be stipulated by both the nominating government and the host government regarding the program,

c) to follow the program, and abide by the rules of the institution or establishment that implements the program,

Date:	Name	Signature

Medical History and Examination

1. Present Status

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

	No		Yes	If yes → Name of Medication		Quantity	

2) Are you pregnant?

	No		Yes	If yes → Months	

3) Are you allergic to any medication or food?

	No		Yes	If yes →		Medication		Food		Other:	

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

2. Medical History

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

Past:		No		Yes	If yes → Name of Illness		Year	
Present:		No		Yes	If yes → Present Condition			

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

Past:		No		Yes	If yes → Name of Illness		Year	
Present:		No		Yes	If yes → Present Condition			

3) High blood pressure

Past:		No		Yes				
Present:		No		Yes	If yes → Present Condition		mm/Hg to		mm/Hg

4) Diabetes (sugar in the urine)

Past:		No		Yes					
Present:		No		Yes	If yes → Present Condition				
					Are you taking any medicine or insulin?		Yes		No

5) Past History: What illness(es) have you had previously?

	Stomach and Intestinal Disorder		Liver Disease		Heart Disease		Kidney Disease
	Tuberculosis		Asthma		Thyroid Problem		
	Infectious Disease → Specify name of illness						
	Other → Specify						

6) 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 result in termination of the program.

Date:	Name	Signature

Official Declaration By The Nominating Government

On behalf of the Government of

I certify that:

a) I have examined the form and I am satisfied that applicant has adequate background;

b) The applicant is medically fit and free from infectious disease and that, having regard to his/her physical and mental history, there is no reason to suppose that the applicant is other than fit to undertake the journey and to remain in host country for the duration of training;

c) Should the nominee seek medical consultation/treatment for his/her pre-existing conditions/illnesses during his period of stay in host country, he would be personally liable for all medical expenses incurred;

d) The applicant has attained a level of proficiency in both spoken and written English to enable him/her to follow the course of study/training for which he/she is being nominated.

I nominate (Dr./Mr./Mrs./Ms.) for the training course.

Name		
Designation		
Organization		
E-mail		Signature

NOTE: This application form should be duly completed and endorsed by the Ministry of Foreign Affairs or the National Focal Point for Technical Assistance in your country. Forms which are incomplete or not endorsed will not be accepted.