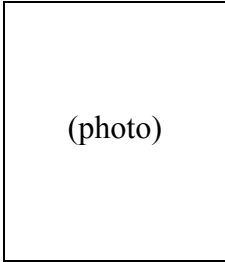


# APPLICATION FORM FOR KOICA TRAINING



## 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	Religion
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:  Governmental/Public  Private  International  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		

1. If the applicant has a history of illness or disorders during the last 5 years, please describe the treatment and present status.

\_\_\_\_\_

\_\_\_\_\_

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?

\_\_\_\_\_

\_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Address of Clinic: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Signature of Physician:** \_\_\_\_\_

**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:	( ) No	( ) Yes>>Name of illness ( ), Place & dates ( )
Present:	( ) No	( ) Yes>>Present Condition ( )

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

Past:	( ) No	( ) Yes>>Name of illness ( ), Place & dates ( )
Present:	( ) No	( ) Yes>>Present Condition ( )

(c) High blood pressure

Past:	( ) No	( ) Yes
Present:	( ) No	( ) Yes>>Present Condition ( ) mm/Hg to ( ) mm/Hg

(d) Diabetes (sugar in the urine)

Past:	( ) No	( ) Yes
Present:	( ) No	( ) Yes>>Present Condition ( )
Present:	( ) No	Are you taking any medicine or insulin? ( ) No ( ) Yes

(e-1) 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 ( )			

(e-2) Has this disease been cured?

( ) Yes	( ) No (Specify name of illness) :
( ) 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:** \_\_\_\_\_