**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:

* 1. Use a computer in completing the form.
  2. Fill in the form in English.
  3. Attach a picture of the Nominee.

1. **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.

**Application Form for the OIC-OSHNET Training Program**

**Information on the Applying Organization**

1. **Profile of Organization**
2. **Name of Organization**
3. **The mission of the Organization and the Department / Division**
4. **Purpose of Application**
5. **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.
6. **Objective:** Describe what your organization intends to achieve by participating in the training program.
7. **Future Plan of Actions:** Describe how your organization shall make use of the expected achievements, in addressing the said issues or problems.
8. **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** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Expectation on the Applied Training Program**
2. **Personal Goal:** Describe what you intend to achieve in the applied training program in relation to the organizational purpose.
3. **Relevant Experience:** Describe your previous vocational experiences which are highly relevant in the themes of the applied training program.
4. **Area of Interest:** Describe your subject of particular interest with reference to the contents of the applied training program.
5. Have you participated in similar training program before? Yes No

|  |  |  |
| --- | --- | --- |
| **Name of program** | **Organizer** | **Year** |
|
|  |  |  |
|  |  |  |

1. **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:

1. To submit/present any report which may be required,
2. 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,
3. 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**
2. Do you currently use any drugs for the treatment of a medical condition? (Give name & dosage.)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Yes | If yes 🡪 Name of Medication |  | Quantity |  |

1. Are you pregnant?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | No |  | Yes | If yes 🡪 Months |  |

1. Are you allergic to any medication or food?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Yes | If yes 🡪 |  | Medication |  | Food |  | Other: |  |

1. Please indicate any needs arising from disabilities that might necessitate additional support or facilities.
2. **Medical History**
3. 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 | | | |

1. 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 | | | |

1. High blood pressure

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Past: |  | No |  | Yes | | | | | |
| Present: |  | No |  | Yes | If yes 🡪 Present Condition |  | mm/Hg to |  | mm/Hg |

1. Diabetes (sugar in the urine)

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

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 |  | | | | | | |

1. **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:

1. I have examined the form and I am satisfied that applicant has adequate background;
2. 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;
3. 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;
4. 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.