



Southeast Asian Ministers of Education Organization
Regional Language Centre
Centre of Choice

MEDICAL EXAMINATION FORM

*APPLICATION FOR MA /DIPLOMA/CERTIFICATE COURSE

Passport-sized
 Photograph

PART A: PERSONAL PARTICULARS (to be completed by Applicant)

1. Name:*(Mr/Mrs/Ms/Mdm)_____ (Please underline surname)
2. Course Code, Course Title and Course Dates:_____
3. Home Address:_____
- Country: _____ Postal code: _____
4. Gender: *Male/Female
5. Date Of Birth:_____ (DD/MM/YYYY)
6. *Passport Number/NRIC No:_____
7. Nationality:_____

*Please delete whichever is not applicable

PART B: MEDICAL HISTORY (to be declared and completed by Applicant)

(Failure to disclose medical history in full may lead to the rejection or cancellation of the application/award).

Have you suffered from or undergone any of the following? Please circle either "Yes" or "No"

- | | | | |
|--------------------------------|----------|--|----------|
| 1 Tuberculosis | Yes / No | 15 Diabetes | Yes / No |
| 2 Pneumonia | Yes / No | 16 Epilepsy | Yes / No |
| 3 Pleurisy | Yes / No | 17 Poliomyelitis or other neurological disorders | Yes / No |
| 4 Asthma | Yes / No | 18 Nervous breakdown | Yes / No |
| 5 Allergic disorders | Yes / No | 19 Psychiatric disorders | Yes / No |
| 6 Rheumatic fever | Yes / No | 20 Eye disorders | Yes / No |
| 7 Heart disease | Yes / No | 21 Ear, nose or throat disorders | Yes / No |
| 8 Gastric orduodenal disorders | Yes / No | 22 Skin diseases | Yes / No |
| 9 Recurrent indigestion | Yes / No | 23 Anaemia | Yes / No |
| 10 Jaundice | Yes / No | 24 Gynaecological disorders | Yes / No |
| 11 Dysentery | Yes / No | 25 Malaria or other tropical diseases | Yes / No |
| 12 Varicose veins | Yes / No | 26 Operations | Yes / No |
| 13 Kidney or urinary diseases | Yes / No | 27 Serious accidents | Yes / No |
| 14 Rupture | Yes / No | 28 Any other serious disorders | Yes / No |
- If Yes, please specify:

 Signature of Applicant

 Date

PART C: CERTIFICATION BY EXAMINING PHYSICIAN (to be completed by physician)

Please tick (√) accordingly.

1. Do you consider the candidate medically fit to undertake a (3 to 6 weeks/more than 6 months)*course of study abroad? (*Please delete whichever is not applicable)

Yes () No ()

If No, please specify reason: _____

2. Additional comments by Examining Physician (if any):

Signature of Examining Physician: _____

Name of Examining Physician: _____

Name of Medical Institution: _____

Address of Medical Institution: _____

Official Stamp: _____

Date: _____