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			
5	Allergic disorders	Yes / No	18	Nervous breakdown	Yes / No
6	Rheumatic fever	Yes / No	19	Psychiatric disorders	Yes / No
7	Heart disease	Yes / No	20	Eye disorders	Yes / No
8	Gastric orduodenal disorders	Yes / No	21	Ear, nose or throat disorders	Yes / No
9	Recurrent indigestion	Yes / No	22	Skin diseases	Yes / No
10	Jaundice	Yes / No	23	Anaemia	Yes / No
11	Dysentery	Yes / No	24	Gynaecological disorders	Yes / No
12	Varicose veins	Yes / No	25	Malaria or other tropical diseases	Yes / No
13	Kidney or urinary diseases	Yes / No	26	Operations	Yes / No
14	Rupture	Yes / No	27	Serious accidents	Yes / No
			28	Any other serious disorders If Yes, please specify:	Yes / No

_____

_____ _____
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: _____