

**SEAMEO TROPED REGIONAL CENTRE FOR  
MICROBIOLOGY, PARASITOLOGY AND ENTOMOLOGY  
SEAMEO TROPED NETWORK  
INSTITUTE FOR MEDICAL RESEARCH,  
MALAYSIA**

**APPLICATION FORM**

(Please TYPE or PRINT in Duplicate)

**Course Title:**

☐

Postgraduate Diploma in Medical Microbiology (DMM)

☐

Postgraduate Diploma in Applied Parasitology and Entomology (DAP&E)

☐

Others including module: \_\_\_\_\_

Affix  
Photo Here

(Please tick the appropriate box for the course that you are interested to attend)

**Course / Module Dates:** \_\_\_\_\_

**Venue/Place:** \_\_\_\_\_

**Sponsor:**

☐ SEAMEO TROPED Network ☐ WHO ☐ Self-Supporting

☐ Other (Specify) \_\_\_\_\_

**B I O D A T A**

|                                                                                                                                             |              |                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------|
| Name of Applicant:                                                                                                                          |              | Sex: <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Marital Status:<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Others                         | Nationality: | Country:                                                              |
| Date of birth (Month/Day/Year):                                                                                                             | Age:         | Place of birth (City & Country):                                      |
| ID/Passport No:                                                                                                                             | Issued at:   | Date:                                                                 |
| Home Address:                                                                                                                               |              | Telephone:<br>Fax:<br>E-mail:                                         |
| Name & Address/Tel/Fax/E-mail of Person to be contacted in an emergency):                                                                   |              |                                                                       |
| Office Address:                                                                                                                             |              | Telephone:<br>Fax:<br>E-mail:                                         |
| Present Position/Occupation:                                                                                                                |              |                                                                       |
| Sector: <input type="checkbox"/> Govt. <input type="checkbox"/> Private <input type="checkbox"/> NGO <input type="checkbox"/> Self-Employed |              |                                                                       |
| Level of Responsibility: <input type="checkbox"/> Managerial <input type="checkbox"/> Supervisory <input type="checkbox"/> Support Staff    |              |                                                                       |

|                                                                                                                                                                            |                 |          |      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------|------|
| Brief Description of Duties & Responsibilities:                                                                                                                            |                 |          |      |
| Percent (%) Devoted to: <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Services<br><input type="checkbox"/> Others (Specify) |                 |          |      |
| Educational Attainment: Certificate/Degree(s) obtained. Date obtained:<br><br>College:<br><br>Post Graduate:                                                               |                 |          |      |
| Awards, Other Fellowships Obtained Venue, Dates:                                                                                                                           |                 |          |      |
| Employment History (in chronological order from the most recent):<br><br>Position (Dates) :<br><br>Institution/Employer:<br><br>Dates:                                     |                 |          |      |
| Research Activities in the last 5 years (Title; Objectives; Funding; Brief Statement of Progress of Results):                                                              |                 |          |      |
| Publications in the last 5 years (Books; Technical Papers; Popular Articles; (Use additional sheets if necessary):                                                         |                 |          |      |
| Membership in Honorary and Scientific Societies:                                                                                                                           |                 |          |      |
| Language Proficiency (Please indicate if "Excellent", "Good", or "Fair"):                                                                                                  |                 |          |      |
|                                                                                                                                                                            | Writing/Reading | Speaking | Both |
| English                                                                                                                                                                    |                 |          |      |
| Others (Specify)                                                                                                                                                           |                 |          |      |
| State briefly reasons for taking the course:                                                                                                                               |                 |          |      |

I, hereby, declare that the answers given above are true and correct.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

**Endorsement of Employer (Head of Department/Unit/Centre/Division)**

Name of Employer :

Address :

Telephone No :

Email Address :

Signature/Dates :

**IMPORTANT:**

1. Please submit one copy of this form to the:

Secretariat  
SEAMEO TROPMED Malaysia  
Institute for Medical Research  
National Institutes of Health  
Ministry of Health, Malaysia  
40170 Shah Alam, Selangor  
MALAYSIA  
+603-3362 8068 / [seameo@moh.gov.my](mailto:seameo@moh.gov.my)

2. The application form must be accompanied by:

- 2.1 Certificate of Health and
- 2.2 Certificate of English Language Proficiency, by duly designated Authorities
- 2.3. Transcript of Academic Records and other requirements
- 2.4 Copy of applicants passport (for Non-Malaysian)
- 2.5 High-Definition (HD) Passport size photo (For Non-Malaysian)

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**(FOR OFFICIAL USE ONLY)**

Action taken: ☐ Approved ☐ Disapproved ☐ Pending

REMARKS: \_\_\_\_\_

By : \_\_\_\_\_

Reference No : \_\_\_\_\_

Date : \_\_\_\_\_

# CERTIFICATE OF HEALTH

### Part I (Fill by the Applicant)

1. Name (Please Print):
2. Age: Date of Birth:
3. Address:
4. I.D. /Passport Number:  
Issued at:  
Date:
5. Medical History:
  - 5.1. Do you have any physical impairment?  
(if yes, please give details):
  - 5.2. Have you ever been treated for mental illness?  
(if yes, please give details):
  - 5.3. In the past two years, have you ever been sick or received medical treatment or physical check-up for blood chemistry, blood pressure, urine analysis, x-ray, heart or others?  
If yes, please give details (name of hospital or clinic, attending physician, disease, diagnosis, result and date)
6. I hereby declare that the above statements are true to my knowledge. If there is any false statement or any truth being withheld. I agree to be responsible to all expenses which will derive from the care of those conditions. I agree to the decision of the Faculty Board Committee to withdraw my student status if it is indicated.

Signed at:

Date:

Applicant's Signature:

**Part II (Fill by a Physician)**

1. Name of Candidate:

Age:

Sex:

Office Address:

Residence Address:

2. Physical Examination:

a. Height:

Weight:

b. Skin:

c. Respiratory System:

d. Circulatory System:

Blood pressure: Systolic/Diastolic:

Heart:

e. Gastrointestinal System:

Abdomen:

Liver:

Spleen:

f. Central Nervous System:

g. Other systems

3. Laboratory Tests:

Urine examination: Specific gravity:

Albumin:

Sugar:

Microscopic:

4. Report on X-ray examination of the chest:  
(For course/module that is more than 8 weeks)

5. Does the examination reveal any physical or mental abnormalities which may interfere with his/her study?

No [ ]

Yes [ ] Describe:

Physician's Signature:

Date:

Physician's name (type or print):

Official Address:

- Note: 1. The Physician has to be a clinician in a government hospital  
2. Please attach this Certificate of Health to the application form  
3. The Certificate should have the seal of the same government hospital