



Fayoum University

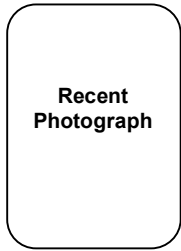
Institute of Strategic Research and Studies for Nile Basin countries

Training Program On

Control of Health Care Associated Infections for Nile Basin Countries

Fully funded by Institute of Strategic Research and Studies for Nile Basin countries

Fayoum University, Egypt



APPLICATION FORM

PART - I Personal information

Name(s):		
Surname:		
Nationality:		
Gender:		
Marital Status:		
Date of Birth (Date - Month – Year).....		
Passport No. : Date & Place of Issue:		
Valid date:		
	Office	Home
Address:		
Tel No.		
Mobile/Cell:		
Fax:		
E-mail:		
Special needs, if any:		
Person(s) to be notified in case of Emergency		
	Official Contact	Personal / Family Contact
Name:		
Address:		
Tel No.		
Mobile/Cell:		
Fax:		
E-mail:		
Qualification		
Degree / Diploma / Certificates	Year	Name of Educational Institute
١.		
٢.		
٣.		
٤.		

Details of Employment (current & previous)

Name of Employer / Department / Company	Position	Period	Description of work
١.			
٢.			
٣.			
٤.			

Are you an employee of: (Mark appropriate box)

a. Government b. Semi-government c. Others

**Please describe in your own words (max ٢٠٠ words):
Reason(s) for applying for this training course**

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Details of present employer

Name / address:
 Tel. No. :
 E-mail:

Have you ever attended a course sponsored by the Government of Egypt? (Mark one) YES / NO

If yes, details:

English language proficiency

	Good	Basic	Remarks
Spoken			
Written			

Mother tongue / Native language:
 Other language(s), if any:

PART – II
Medical History

1. Present Medical Status

(a) Do you currently use any medicine or have regular medical checkup by a physician for your illness?

<input type="checkbox"/> No	<input type="checkbox"/> Yes : Name of illness (), Name of medicine ()
	If yes, please attach your doctor's letter (preferably, written in English) That describes current status of your illness and agreement to join the Program.

(b) Are you pregnant?

<input type="checkbox"/> No	<input type="checkbox"/> Yes : Months of pregnancy (months)
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(c) Are you allergic to any medication or food?

<input type="checkbox"/> No	<input type="checkbox"/> Yes: What are you allergic to? ()
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(d) Please indicate any needs arising from disabilities that might necessitate additional support or facilities.

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2. Past Medical History

(a) Have you had any significant or serious illness?

<input type="checkbox"/> No	<input type="checkbox"/> Yes : Please specify ()
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(b) Have you ever been a patient in a mental clinic or been treated by a psychiatrist?

<input type="checkbox"/> No	<input type="checkbox"/> Yes : Please specify ()
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3. Other Medical Problem

If you have any medical problems that are not described above, please indicate below.

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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 and may result in termination of the program.

Date	Signature
	Print Name

PART – III

Nominating Government/Employer

to be completed by the authorized official

I, on behalf
of the Government of

Nominate Mr./Mrs./Miss to the planned training course

I have examined the educational, professional and other documents quoted by the nominee in
Part – I of this form and I agree that they are authentic and relate to the nominee.

He / She has adequate knowledge of spoken and written English to be able to follow the
training course, he/she applied for.

Name of Nominating Authority:

Designation:

Address:

Date:

Place:

Signature
(With seal)
Name and Designation
(In block letters)

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To be attached with the application:

- Motivation letter.
- Certified English translated - scanned copy Bachelor / Master degree/diploma.
- CV/Resume in English.
- Proof of English proficiency, if any.
- Copy valid passport.