

be contacted in an emergency
(including telephone number).

Relationship of this person to you: _____

11. Have you ever travelled abroad before?
If YES, give details.

12. Give details of any disability, or any
medical condition which may require
treatment during your training, or any
dietary restrictions.

13. Please make an assessment of your ability in English (Circle as
Appropriate)

Reading: Excellent/Good/Average/Poor
Writing: Excellent/Good/Average/Poor
Speaking: Excellent/Good/Average/Poor

14. **Education Record**

If possible attach copies (NOT the originals) of your academic
transcripts, etc. Include any professional attachments, short
courses or workshops which you have attended. Indicate any
courses being taken, expected date of completion, and the
qualification to be obtained.

<u>Institution</u>	<u>Location</u>	<u>Dates Attended</u>		<u>Qualifications obtained & subjects studied</u>
		<u>From</u>	<u>To</u>	

15. Please give details of any other professional qualifications not mentioned above.

16. **Employment Record**

Please list current occupation first and then your 2 previous posts.

Current Employer
(and nature of business):

Job Title:

Dates:

Duties of the Post:

Previous Employer
(and nature of business):

Job Title:

Dates:

Duties of the Post:

Previous Employer
(and nature of business):

Job Title:

Dates:

Duties of the Post:

17. **Personal Statement**

Please describe briefly those aspects of your present work which relate to the training requested.

How will the training help?

Are there other skills which the training should cover?

18. **Undertaking**

I _____ (*name in CAPITALS*)

of _____ (*Country*) certify that the statements

made by me in Part I of this form are true, complete, and correct

to the best of my belief.

I also fully understand that if I am granted an award it may subsequently be withdrawn if I fail to make adequate progress, of for other sufficient cause determined by GIDD, my own, or the host Government I undertake to return to my country after completion of the training programme.

Except as mentioned in 12 above, I confirm that I am in good health.

Signature: _____ Date: _____

FORM GID/1 Part II

The Commonwealth Secretariat
GOVERNANCE & INSTITUTIONAL DEVELOPMENT DIVISION (GIDD)

TRAINING REQUIREMENTS

To be completed by the employer

1. Name of Nominee _____

If others are nominated for this training please indicate their priority relative to the nominee.

<u>Higher Priority</u>	<u>Equal Priority</u>	<u>Lower Priority</u>
1.	1.	1.
2.	2.	2.
3.	3.	3.

2. Training Needs

Please indicate the subject, nature, and level of the training requested.

Why is the training required? (Please indicate relevance to national development.)

Describe any particular problems which the training is intended to help solve.

(Continue on a separate sheet if necessary)

3. Content & Objectives of the Training

 Please specify in as much detail as possible:-

- why the nominee was selected.

- what post he/she will fill on return.

- the skills you wish him/her to acquire.

(Continue on a separate sheet if necessary)

4. Other Sources of Assistance or Sharing of Costs

Are you requesting assistance from elsewhere? Give details. Yes/No*

If partial assistance were offered by GIDD, is your Government or any other source prepared to meet any part of the cost? Yes/No*
Please give details

Complete either or and Section A for formal courses,
Section B – study visits for training attachments
the section on Costs.

A For formal courses

5. If you have a particular courses in mind, please give:-
- exact course title

- institution & country

- course start dates & duration
(if known)

Has an application been made by or on behalf of the nominee(s)? (If so, please give details and attach copies of any response, other, or rejection. Yes/No

6. If you do not know of a particular course, please give (on a separate sheet) as much information as possible to assist in identifying a suitable programme; eg specific subject areas, specializations, and possible countries or institutions.

B Study Visits & Attachments

- 7. If you know of any suitable places for the visit or attachment, please give details, including the address of the host organisation, dates/duration, details of the required training, and copies of any relevant correspondence.

- 8. If no approach has been made, please give details of the visits/experiences to which the nominee(s) should be exposed, with details of their present and future work. Include details of industrial processes, machinery or equipment used.

(Continue on separate sheet)

9. Anticipated Cost of Training

Please give anticipate costs for the training as shown below, indicating whether these are known, estimated, or unknown. (Please attach explanatory documents where appropriate.) **Please note that the absence of this information may delay Processing.**

- Travel**
- Fees**
- Subsistence Allowance**
- Other costs** *(specify)*

10. Please comment, if appropriate, on any answers given by the nominee in Part 1.

11. I confirm that I believe all the statements in this form to be correct.

Signed: _____ Position: _____

Name: _____ Date: _____ Organization: _____

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MEDICAL CHECK UP FORM

**MEDICAL HISTORY AND EXAMINATION FOR THE TRAINING AWARD
(TO BE COMPLETED BY NOMINEE)**

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Name of Nominee (as in International Passport)		
Date of Birth	Gender Male / Female	Nationality

Name of Training Course:

IMPORTANT:

Before you complete the Medical History, you are hereby notified that: A medical condition resulting from an undisclosed pre-existing condition may not be financially compensated for COMSEC and INFRA and may result in termination of your training programme.

I understand and accept the terms to notice. YES / NO

NOMINEE WILL CHECK "YES" OR "NO" AND EXPLAIN WHERE NECESSARY

	YES	NO		EXPLANATION
a			Have you had any significant or serious illness or injury? (if hospitalized, give place & dates)	
b			Have you had any operations or advised by physician to have an operation? (Give place & date)	

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c			Do you currently use any drugs for treatment of a medical condition? (Give name & dose)	
d			Have you ever been a patient in a mental hospital or sanatorium or treated by a psychiatrist? (Give place & date)	

NOMINEE WILL INDICATE "YES" OR "NO" TO EACH ITEM

Do you now have you ever had the conditions listed below? (Please tick)

	YES	NO	EXPLANATION
a			Asthma, emphysema, or other lung conditions
b			Tuberculosis or live with anyone who has tuberculosis
c			High blood pressure, heart disease
d			Stomach, liver(hepatitis), gall bladder disease

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e			Kidney or bladder disease, stone or blood in urine
f			Diabetes (sugar in urine)
g			Depression, excess worry, attempted suicide, or other psychological symptoms
h			Acquired Immune Deficiency Syndrome (AIDS)
i			Tumor, abnormal growth, cyst or cancer
j			Bleeding disorder, blood disease (sickle cell anemia)

I CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND ANSWERED ALL QUESTIONS TRULY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE:

NAME:	DATE:	SIGNATURE:

MEDICAL REPORT (TO BE COMPLETED BY AN AUTHORIZED PHYSICIAN)

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Name of Applicant:			
Age:	Weight:	Gender:	Height:
Blood group:		Blood pressure:	
Is the person examined at present in good health?			
Is the person examined physically and mentally able to carry out intensive training away from home?			
Is the person free of infectious disease (AIDS, tuberculosis, trachoma, skin disease, SARS etc)?			
Does the person examined have any condition of defect (including teeth) which might require treatment during the course?			
List any abnormalities indicated in the chest X-Ray.			

Pregnancy Test result (for women only):

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I certify that the applicant is medically fit to undertake a course in Malaysia.

Name of Physician:

Address of Clinic/Hospitals:

Telephone No.: _____ No./Fax: _____

Email: _____

Signature of Physician: _____

Seal/Stamp of Clinic/Hospital:

