

IV. DECLARATION

I, _____, of _____
(name of applicant) (name of country)

certify that the statements I made in this form are **true and correct** to the best of my knowledge.

If accepted for the program, I agree to **respect SP Participant Guideline** and **Code of Conduct** set forth above.

If I fail to comply the terms and conditions of KOICA Scholarship Program,

I will **accept any penalties and consequences** including dismissal from the Program

and report to my government and/or employer.

Date: _____ Applicant's Name: _____ Signature: _____

PART 3. MEDICAL HISTORY QUESTIONNAIRE

MEDICAL HISTORY QUESTIONNAIRE (to be completed by the applicant)

1. Present Status

- a. Do you currently use any drugs for the treatment of a medical condition? (give name & dosage)

☐ No ☐ Yes >> Name of Medication (), Quantity ()

- b. Are you pregnant? (female only)

☐ No ☐ Yes >> (months)

- c. Please indicate any needs arising from disabilities that may require additional support or facilities.

()

Note: Disability does not lead to dismissal or exclusion from the Program. However, upon the situation, you may be directly inquired by the KOICA Program Manager for more detailed account of your condition.

2. Medical History

- a. Have you had any significant or serious illnesses? (If hospitalized, give place & dates.)

Past: ☐ No ☐ Yes >> Name of illness (), Place & dates ()

Present: ☐ No ☐ Yes >> Present condition ()

- b. Have you ever been a patient in a mental hospital or have been treated by a psychiatrist?

Past: ☐ No ☐ Yes >> Name of illness (), Place & dates ()

Present: ☐ No ☐ Yes >> Present condition ()

- c. High blood pressure

Past: ☐ No ☐ Yes

Present: ☐ No ☐ Yes >> • Present condition () mm/Hg to () mm/Hg
• Are you taking any medicine? ☐ No ☐ Yes

- d. Diabetes (sugar in the urine)

Past: ☐ No ☐ Yes

Present: ☐ No ☐ Yes >> • Present condition ()
• Are you taking any medicine or insulin? ☐ No ☐ Yes

- e. What illness(es) have you had previously?

☐ Thyroid Problem ☐ Liver Disease ☐ Heart Disease ☐ Kidney Disease

☐ Tuberculosis ☐ Asthma ☐ Stomach and Intestinal Disorder

☐ Infectious Disease >> Specify the name of illness ()

☐ Others >> Specify ()

- f. Has the above illness(es) been cured?

☐ Yes ☐ No
- Specify the name of illness ()
- Present condition ()

I certify that I have answered all questions truthfully and completely to the best of my knowledge.

Date: _____ Applicant's Name: _____ Signature: _____

PART 4. NOMINATION

I. OFFICAL NOMINATION (to be completed by nominating government / organization)

The Government of _____ officially nominates _____
(Name of Country) (Full Name of Nominee)
to participate in _____ as organized by the Korean Government(KOICA)
(Title of Program)
and I, _____, on behalf of the Government of _____, certify that
(Name of Authorized Official) (Name of Country)

- (a) All information including career and educational background quoted by the nominee in this form is true, complete and accurate to the best of my belief and knowledge.
- (b) The nominee has an adequate knowledge of and/or expertise in the training field and has a sufficient proficiency of the language required, both spoken and written, to undergo the Scholarship Program.
- (c) On behalf of the organization I agree to the terms and conditions of KOICA.
- (d) My organization shall be responsible for dealing with claims by KOICA and third parties where the loss or damage to their property, or death or personal injury was caused by gross negligence or willful misconduct of the Nominee during the participation to the KOICA Scholarship Program.
- (e) **Nominee's unsatisfactory performance or failure to conform to the code of conduct may lead to limited opportunities for the organization's nomination to the KOICA Fellowship Program.**

Name(Authorized Official) : _____

Position/Title: _____ Organization: _____

Telephone: _____ Email: _____

Date: _____ Signature: _____

(Official Stamp Included)

II. ORGANIZATION CHART with an appropriate marking of the nominee's position