

学员报名表 Application Form

Name of the seminar/training course: 项目名称:			
性质	官员 <input type="checkbox"/> 技术 <input type="checkbox"/>	培训时间	培训地点
照片 Photo	Family name 姓		
	First name 名		
	Position 职务		
	级别	部级及以上 <input type="checkbox"/> 司局级 <input type="checkbox"/> 处级及以下 <input type="checkbox"/>	
	建议舱位	头等舱 <input type="checkbox"/> 商务舱 <input type="checkbox"/> 经济舱 <input type="checkbox"/>	
Passport No. 护照号码			
Nationality 国籍		Name of institute 工作单位名称	
Sex 性别			
Language 工作语言		Mail Address of Institute 工作单位地址	
Religion 宗教			
Food abstention 饮食禁忌		Address of Home 家庭住址	
Date of Birth 出生日期			
Tel		Email	
Fax		Person to be contacted in emergency 应急联络人	
Cellphone		Phone to be contacted in emergency 应急电话	
Signature (本人签字)		Date (日期)	
经商参处意见:			

Note: Please fill in the blanks with English label.

外国人体格检查记录

Physical Examination Record for Foreigner

姓名 Name		性别 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期 Birth Day-Month-Year		照 片 Photo
现在通讯地址 Present Mailing Address					血型 Blood type	
国籍 Nationality		出生地址 Birth Place				
过去是否患有下列疾病 (每项后面请回答“否”或“是”) <i>Have you ever had any of the following diseases?</i> <i>(Each item must be answered "Yes" or "No")</i>						
斑疹伤寒	Typhus fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	菌痢	Bacillary dysentery	<input type="checkbox"/> No <input type="checkbox"/> Yes
小儿麻痹症	Poliomyelitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	布氏杆菌病	Brucellosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
白喉	Diphtheria	<input type="checkbox"/> No	<input type="checkbox"/> Yes	病毒性肝炎	Viral hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
猩红热	Scarlet fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	产褥期链球菌感染	Puerperal streptococcus infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
回归热	Relapsing fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
	伤寒和副伤寒	Typhoid and paratyphoid fever				<input type="checkbox"/> No <input type="checkbox"/> Yes
	流行性脑脊髓膜炎	Epidemic cerebrospinal meningitis				<input type="checkbox"/> No <input type="checkbox"/> Yes
是否患有下列危及公共秩序和安全的病症: (每项后面请回答“否”或“是”) <i>Do you have any of the following diseases or disorders endangering the public order and security?</i> <i>(Each item must be answered "Yes" or "No")</i>						
	毒物癖	Toxicomania				<input type="checkbox"/> No <input type="checkbox"/> Yes
	精神错乱	Mental confusion				<input type="checkbox"/> No <input type="checkbox"/> Yes
	精神病	Psychosis: 躁狂型 Manic Psychosis				<input type="checkbox"/> No <input type="checkbox"/> Yes
		妄想型 Paranoid Psychosis				<input type="checkbox"/> No <input type="checkbox"/> Yes
		幻觉型 Hallucinatory Psychosis				<input type="checkbox"/> No <input type="checkbox"/> Yes
身高 Height	cm	体重 Weight	kg	血压 Blood pressure	mmHg	
发育情况 Development		营养情况 Nourishment		颈部 Neck		
视力	左 L _____ 右 R _____	矫正视力	左 L _____ 右 R _____	眼 Eyes		
辨色力 Colour Sense	皮肤 Skin		淋巴结 Lymph nodes			
耳 Ears	鼻 Nose		扁桃体 Tonsils			
心 Heart	肺 Lungs		腹部 Abdomen			

脊柱 Spine	四肢 Extremities	神经系统 Nervous system																								
其它所见 Other abnormal findings																										
胸部 X 线 检查 Chest X-ray Exam.		心电图 E C G																								
化验室检查 包括血清学诊断 Laboratory Exam. (Serodiagnosis)																										
<p style="text-align: center;">是否发现患有下列检疫传染病和危害公共健康的疾病： <i>Do you have any of the following diseases or disorders found during the present examination?</i> <i>(Each item must be answered "Yes" or "No")</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">霍乱</td> <td style="width: 15%;">Cholera</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td style="width: 15%;">性病</td> <td style="width: 15%;">Venereal Disease</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>黄热病</td> <td>Yellow fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>开放性肺结核</td> <td>Opening lung tuberculosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>鼠疫</td> <td>Plague</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>艾滋病</td> <td>AIDS</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>麻风</td> <td>Leprosy</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>精神病</td> <td>Psychosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> </table>			霍乱	Cholera	<input type="checkbox"/> No <input type="checkbox"/> Yes	性病	Venereal Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	黄热病	Yellow fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	开放性肺结核	Opening lung tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	鼠疫	Plague	<input type="checkbox"/> No <input type="checkbox"/> Yes	艾滋病	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	麻风	Leprosy	<input type="checkbox"/> No <input type="checkbox"/> Yes	精神病	Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
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意见 Suggestion	检查单位盖章 Official Stamp																									
医师签字 Signature of Physician	日期 Date																									

ESSENTIAL INFORMATION OF THE NOMINEE

1 1.1 Title of Training Programme

1.2 Duration in Weeks

1.3 ERD Code

2 2.1 Ministry.....

2.2 Agency.....

3 3.1 Name of Nominee

(Please Enter Family Name First and Underline Family Name Only)

3.2 Sex

3.2 National Identity Card Number 3.3 Passport Number:

3.4 Present Designation

3.5 Designation Group of the Nominee in the Agency (Indicate the appropriate box)	Management or Technical Grade			Technician, Supportive & Allied Groups	Other (Specify)
	Senior Level	Middle Level	Junior Level		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 4.1 Official Address..... 4.2 Phone/Fax.....
..... 4.3 e-mail

5 Telephone/Fax for Urgent Contact.....

6 6.1 Date of Birth Date Month Year.

6.2 Age at the Commencement of the Programme (To the Closest Year) Years

7 7.1 Years of Service to the Government in the Nominee's Career Years

7.2 Nominee's Years of Service in the Present Agency Years

8 Educational Qualifications (Please Use Abbreviations to Describe)

8.1 Academic Qualifications of the Nominee	Sp. Degree (4yr)	General Degree (3yr)	Other First Degrees & Equivalent Full Professional Qualifications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.2 Performance at the First Degree	Ordinary Pass	2nd Class Lower	2nd Class Upper	First Class	Not Relevant
(Please Check in case of Special and General Degrees only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.3 Institute and year.....

9 Local Long Term Training Successfully Completed & Full Professional Qualifications Achieved by Nominee

9.1 Masters Degree	<input type="text"/>	Indicate the Number Only
9.2 Post Graduate Diploma	<input type="text"/>	Indicate the Number Only
9.3 Medium Term Training of more than three month Duration	<input type="text"/>	Indicate the Number Only
9.4 Full Professional Qualifications	<input type="text"/>	Indicate the Number Only

10 Local Short Term Training Received by the Nominee

Total number of local training received

11 Previous Foreign Training Received by the Nominee

11.1 Foreign Training each less than one week duration received in the **Past 3 Years**

Total number of training

11.2 Foreign Training Each Greater than one week & Less than 12 weeks(threc months) duration received in the **Past 3 Years**

Total number of training

11.3 Foreign Training Each Greater than 12 weeks & Less than 32 weeks duration received in the **Past 3 Years**

Total number of training

11.4 Foreign Training Each Greater than or equal to 32 weeks Duration in Nominee's Career (Training Funded by the Government of Sri Lanka or Funded by a Scholarship offered to the Government of Sri Lanka)

Nominee has received at least one training opportunity of duration greater than 32 weeks

12 Nominee's Declaration

I, the undersigned, certify that the details provided in this correctly describe myself, my qualifications and my experience.

12.1 Date:

12.2 Nominee's Signature

13 Certification of the Head of Department

Relevancy of this Training Programme to Nominee's Work (Please Check only one Box)	Vital for present work	Directly Related to Present Work	Connected to Present Work	Helpful in Future Work	For Promotions	Other (Specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Main Function of the Agency in the Field of Training (Please Check only one Box)	Execution	Supervisory	Training/Teaching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify the accuracy of the information given above.

.....
Signature of Head of the Department and Stamp

Date: