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**Chulabhorn Graduate Institute - The ASEAN Foundation
Joint Post-Graduate Scholarship Program
Scholarship Application Form
(For ASEAN Applicants)**

IMPORTANT INSTRUCTIONS:

- Each question must be answered clearly and completely.
- Duly completed application forms should be forwarded to the Chulabhorn Graduate Institute before deadline of application
- Incomplete applications will not be considered.

- Proposed field of study:**
- Applied Biological Sciences: Environmental Health
- Environmental Toxicology
- Chemical Biology

PERSONAL DATA

Title	Family name / Surname (as shown in passport)	First name			Sex
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.					<input type="checkbox"/> Male <input type="checkbox"/> Female
City and country of birth	Nationality	Date of Birth (DD/MM/YY)	Age	Marital Status	Religion
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	

COMMUNICATION AND MAILING ADDRESS

Applicant's Office Address:		Applicant's Home Address:	
Office telephone NO:	FAX:	Home telephone NO:	FAX:
Country Area Number	Country Area Number	Country Area Number	Country Area Number
Office Email:		Personal Email:	
Name and address of person to be notified in case of emergency:			
Telephone No:		Relationship:	
Country Area Number			
International Airport / City of Departure			

EDUCATION RECORD

Education Institution	City/ Country	Years Attended		Degrees, Diplomas and Certificates	Major field of study	Cumulative GPA
		From	To			
Have you ever been trained in Thailand? If yes, what course, where and for how long?						
List of your publications/researches (do not attach details)						

EMPLOYMENT RECORD

Present or most recent post: Employer:	Previous post: Employer:
Years of service (from-to):	Years of service (from-to):
Title of your post/position:	Title of your post/position:
Type of your organization: Government/ Semi Government/ Private/ NGO	Type of your organization: Government/ Semi Government/ Private/ NGO
Main function of the organization:	Main function of the organization:
Office address:	Office address:

Description of your work including your responsibilities (Please continue on supplementary pages if necessary)

EXPECTATIONS

Please describe the practical use you will make of this study on your return home in relation to the responsibilities you expect to assume and the condition existing in your country in the field of your training. (Please continue on supplementary pages if necessary)

LANGUAGES (No consideration will be given to applicants without language proficiency test documents)

	Read			Write			Speak		
	Excellent	Good	Fair	Excellent	Good	Fair	Excellent	Good	Fair
Mother tongue									
.....									
English									
Other									

English Proficiency Test* (please attach)

TOEFL Score

IELTS Score

Other (specify)

*Required Information

SUPPORTING DOCUMENTS

Transcript (s)

Letter of Recommendation

name	title	institution/company
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name	title	institution/company
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name	title	institution/company
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Medical Certificate

Others (Please specify) _____

Please read the following and sign

I understand that withholding pertinent information requested in this application form or intentionally giving false information will make me automatically ineligible for application consideration. I hereby certify that my education and qualifications are in accordance with the admission requirements and all information given in this form is true.

Applicant's Signature

Date

Duly completed application form should be forwarded to:

The Chulabhorn Graduate Institute
(CGI-AF Joint Scholarship Program)
54 Kamphangphet 6 Road, Talat Bang Khen,
Laksi, Bangkok 10210
THAILAND

Email: cgi_academic@cgi.ac.th

<http://www.cgi.ac.th>

Medical History and Report

Name of Nominee Age

Country.....

***Physical Examination (To be filled in by physician)**

Present Status

Height Cms. Weight kgs. Blood Pressure mm.Hg. Pulse/min.

Vision Right Left Eyes With glasses / Without glasses

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

No

Yes : name of medication (.....), Quantity (.....)

b) Are you pregnant?

No

Yes : (..... months)

c) Are you allergic to any medication or food?

No

Yes : () Medication : () Food : () Other:

Laboratory Examinations

Blood group Blood film for malaria Hb gm%

WBC Cells/cu.mm.

Differential PMN % Lymph % Mono % Eos %

Baso % Band % Blast %

Urinalysis : Colour Sp. Gr pH Sugar

Alb Blood Ketones Blie.....

Micro : WBC...../HPF.,RBC/HPF.,Epethelial...../HPF.

Casts...../HPD., Others

Stool examination for parasite & Ova

Chest X - Ray report

Urine pregnancy test

Check each item in appropriate column

Item	Normal	Abnormal	Additional comment
General	<input type="checkbox"/>	<input type="checkbox"/>
Skin, Scalp	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>
Otoscope Exam			
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Pharynx & tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid gland	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>
Spleen	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Rectal exam.	<input type="checkbox"/>	<input type="checkbox"/>
Vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
Locomotor	<input type="checkbox"/>	<input type="checkbox"/>
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Mental health status	<input type="checkbox"/>	<input type="checkbox"/>

Is the nominee able physically and mentally to carry on intensive study away from home?

.....

Is the nominee free from infectious diseases (such as tuberculosis, leprosy, syphilis and filariasis) and other conditions (such as psychosis and drug addiction) which could present risks for anyone during the fellowship period?

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Does the nominee have any condition or defect which might require treatment during the fellowship period?

.....

Full name and address of
Examining physician (printed)

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.....

Physician signatureM.D.

(.....)

Date