

ID/
Nominations
Fellowship

විදේශ සම්පත් දෙපාර්තමේන්තුව
வெளிநாட்டு வளங்கள் திணைக்களம்
Department of External Resources

இதன் அலுவலகம்
මහලේකම් කාර්යාලය සි විජි මහල, තැ.පෙ. 277, කොළඹ 00100, ශ්‍රී ලංකාව

நிதி அமைச்சு
செயலகம் (3 ஆம் மாடி), த. பெ. இல. 277, கொழும்பு 00100, இலங்கை

Ministry of Finance
The Secretariat (3rd Floor), P.O. Box 277, Colombo 00100, Sri Lanka

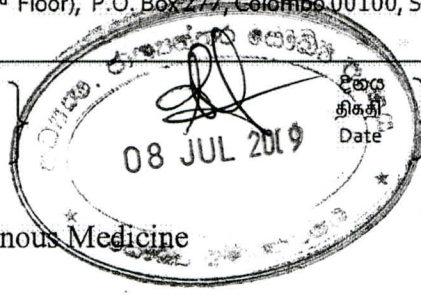
Web Site: www.erd.gov.lk

e-mail: info@erd.gov.lk

මගේ අංකය
எனது இல
My No

TA/CHI/H/2019/04

ඔබේ අංකය
உமது இல
Your No



දිනය
திகதி
Date

03 July 2019

Secretary
Ministry of Health, Nutrition & Indigenous Medicine

Dear Sir/Madam

**Training Course on Ophthalmological Technology for BRI Countries
- from 27 July to 20 August 2019 - China**

The Government of China has invited nominations from eligible Government Officials in Sri Lanka for the above training programme. The officials who attended in a training programme funded by the Chinese Government within last 02 years are not entitled to apply for this training programme.

Therefore, you are kindly requested to submit **04 nominations** along with the following documents **as soon as possible**.

1. Duly filled Application Form,
2. A copy of the passport. (The expiry date of the passport shall be not less than 6 months from the ending of the Seminar).
3. Duly filled ERD Form 2
4. Medical Report (All the applicants without considering the age have to provide the medical report).

A copy of the programme details, Application Form, ERD Form 2 and the Medical Report in this regard are enclosed.

General conditions for Chinese training programmes.

- Should send only the requested number of nominations.
- Applications will not be accepted after ERD closing date.
- One official can apply only for one programme at once.
- All the selected participants must wear a formal dress when they meet the officials at the Embassy of the People's Republic of China in Sri Lanka and they should be there on time.
- Selected participants should participate in all the lectures & all events conducted under the training programme.

අධ්‍යක්ෂ ජනරාල්
பணிப்பாளர் நாயகம்
Director General

94-11-2484693

කාර්යාලය
அலுவலகம்
Office

94-11-2484500
94-11-2484600

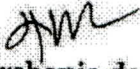
ෆැක්ස් අංකය
தொலை நகல்
Fax

94-11-2447633
94-11-2387153
94-11-2434876

- Scheduled dates of the training programmes could be changed due to unavoidable circumstances occurred by the Chinese government.
- Some training programmes could be cancelled or postponed.
- Air Tickets may be issued most probably one day before the departure.
- Selected Participants may be informed by the Embassy of the People's Republic of China in Sri Lanka most probably within one week before the training programmes begin.
- Course details may be given to the participants on the day before they leave the country or may be received in China.

Your early attention in this regard is highly appreciated.

Yours faithfully


L. A. Y. Darshanie de Silva
Director / TA Division
for Director General

Copy to: **Director**, Eye Hospital of Sri Lanka

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	
现在通讯地址 Present Mailing Address				血型 Blood type	照 片 Photo
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>					
毒物瘾 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 Vision	左 L _____ 右 R _____	矫正视力 Corrected vision	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>是否发现患有下列检疫传染病和危害公共健康的疾病： Do you have any of the following diseases or disorders found during the present examination? (Each item must be answered "Yes" or "No")</p> <table border="0"> <tr> <td>霍乱 Cholera</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>性病 Venereal Disease</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>黄热病 Yellow fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>开放性肺结核 Opening lung tuberculosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>鼠疫 Plague</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>艾滋病 AIDS</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>麻风 Leprosy</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>精神病 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
霍乱 Cholera	<input type="checkbox"/> No <input type="checkbox"/> Yes	性病 Venereal Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes															
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麻风 Leprosy	<input type="checkbox"/> No <input type="checkbox"/> Yes	精神病 Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes															
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(three 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"/>
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: