

Attach

Recent

Photograph

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(Approx. 4x5cm)

**CANDIDATE’S BIODATA**

**(Please type or print)**

|  |
| --- |
| **Project code:** |
| **Project title:**  |

## **A. PERSONAL DATA**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | Dr./Mr./Mrs./Ms. Other ( )(Please type your name as indicated in your passport. Underline surname/family name. Include Chinese characters, if any)  | **Passport** | Number: |
| Date and Place of Issue: |
| Expiry Date:  |
| **NATIONALITY** |  | **DATE OF BIRTH****Yr: M: D:** |
| SEX: MALE / FEMALE |
| PRESENT POSITION |  | **SINCE** |  |
| **NAME OF COMPANY/ ORGANIZATION** | URL: http:// | **DATE JOINED** |  |
| **ADDRESS OF THE COMPANY/ ORGANIZATION** | Address: Tel: Fax:e-Mail:   |
| TYPE OF BUSINESS |  | **TOTAL NO.** **OF EMPLOYEES** |  |
| TYPE OF ORGANIZATION |  Govt. ministry/ University/  agency institutions  Govt/ state/ local govt. NGO/ owned enterprise association  | If private company: SME  Non-SME |
| PERSONAL CONTACT DETAILS | Tel (home) Mobile phone (Optional): e-Mail (Important): |
| CONTACT PERSON IN CASE OF EMERGENCY | Name: Relationship:Address: Tel: Fax: e-Mail: |
| DIETARY RESTRICTIONS | If any, please specify:  |

**(Kindly be informed that this biodata form must be submitted and processed through the National Productivity Organization (NPO) of the respective member country. Forms sent directly to the APO Secretariat will not be processed or acknowledged. A soft copy of the form can be downloaded from the APO Web site at www.apo-tokyo.org.)**

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| --- |
| B. ACADEMIC QUALIFICATIONS |
| University/Institution**(Bachelor and postgraduate only)** | **Major Field of Study** | Cert. /Diploma/Degree | Year |
|  |  |  |  |
| C. TRAINING/SEMINAR (last 5 years only) |
| University/Institute/Org. | Major Field of Training/Seminar | **Year**  |
|  |  |  |
| 1. **PARTICIPATION IN OTHER APO PROJECTS (last 5 years only)**
 |
|  YES NO If yes, please specify below |
| **PROJECT** | **DATES** | **YEAR** |
|  |  |  |

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| --- |
| **E. PRESENT JOB DUTIES/ACTIVITIES** |
| State your present job duties and other activities in consultancy, training, research, and publication relevant to the project. Please attach organization chart and highlight your position.  |
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| **F. PREVIOUS EMPLOYMENT/JOB EXPERIENCE (last five years)** |
| For each previous employment/job experience, please give designation, organization worked for, period of employment, and job duties. |

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| G. OBJECTIVE FOR PARTICIPATION |
| Kindly refer to the Project Notification, and state relevancy of project to your work, and indicate your expectation(s) from the project. |
|  |
| **H. DECLARATION BY CANDIDATE** |
| I hereby declare that I have read and understood the APO Project Notification for this project. I further declare that the information as provided by me in this document is true and accurate. I understand and accept that any false declaration of information on my part will disqualify me from the project, even when it is in progress.I hereby also undertake to abide by the regulations prescribed by the APO, the host country(ies), and the implementing organization(s) during the entire period of this project and to participate fully in it. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Name:  |
| **I. CONFIRMATION OF CANDIDATE’S ENGLISH LANGUAGE PROFICIENCY**(to be filled in by APO Director/Alternate Director/Liaison Officer) |
| The candidate’s English language proficiency has been evaluated as: As fluent as the candidate’s native language. Competent to participate in discussion and express him/herself. Proficient enough to follow lectures/discussions, but will have difficulties  in expressing ideas and giving comments. I further certify that the candidate belongs to: SME Profit-making organization (non-SME) Nonprofit organization Signature: Name: Ratchada Asisonthisakul Designation: APO Liaison Officer for Thailand Date: |

# ASIAN

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**PRODUCTIVITY**

**ORGANIZATION**

## APO MEDICAL AND INSURANCE DECLARATION FORM

Only for applicants without any of the health conditions listed on the reverse side

|  |
| --- |
| 1. NAME (family name, first name, middle name)
 |
| 1. DATE OF BIRTH
 | 1. NATIONALITY
 | 4. SEX ( ) Male  ( ) Female |
| 1. APO PROJECT CODE AND NAME (VENUE)
 |
| I confirm that:1. I have read carefully the project notification for the above APO project and declare that I have the physical and mental fitness to attend the APO project.
2. I have had no health conditions listed on the reverse side during the last 5 years and am free from any ailment likely to impair the health of others or affect my participation in the APO project.
3. I will secure the required comprehensive travel insurance as specified in the project notification for the above APO Project.
4. I understand that neither APO nor the implementing organization will be liable for any medical or other costs incurred during the project, except for those specifically stated in the Project Notification.
5. I will bring with me the necessary medications for minor illness as prescribed by my physician since they may not be readily available at the venue of the above APO project.

   Date Signature |

## **APO MEDICAL AND INSURANCE CERTIFICATION FORM**

Only for applicants with one or more of the health conditions stated under item 6 below

|  |
| --- |
| 1. NAME (family name, first name, middle name)
 |
| 1. DATE OF BIRTH
 | 1. NATIONALITY
 | 4. SEX ( ) Male ( ) Female |
| 1. APO PROJECT CODE AND NAME (VENUE)
 |
| 6. Please indicate “Yes” or “No” if you have had any of the following during the last 5 years: | YES | NO |
| a. Tuberculosis, asthma, emphysema, or other respiratory illnesses |  |  |
| b. High blood pressure, heart bypass, heart attack, or other heart condition |  |  |
| c. Stomach ulcer, liver disease (hepatitis), gall bladder disease |  |  |
| d. Kidney disorder, stone or blood in urine |  |  |
| e. Diabetes, sugar or glucose in blood or urine |  |  |
| f. Depression, attempted suicide, or other psychological symptoms |  |  |
| g. Tumor, abnormal growth, cyst, or cancer |  |  |
| h. Bleeding disorder, blood disease (sickle-cell anemia) |  |  |
| i. Malaria, cholera, smallpox, or infectious disease |  |  |
| 1. Allergy
 |  |  |
| k. Other serious illness (please specify) |  |  |
| I certify that the above information is true and correct to the best of my knowledge. I understand that neither the APO nor the implementing organization will be liable for any physical or mental problem that I may develop during my participation in the APO project and that I shall be responsible for bringing with me necessary medications as prescribed by my physician since they may not be available at the venue of the project. Further, I understand that I must secure the required comprehensive travel insurance as specified in the project notification for the above APO Project.  Date Signature |
| TO BE COMPLETED BY A PHYSICIAN |
| Based on the information above, I have examined the applicant and certify that he/she is free from any ailment likely to impair the health of others and is fit to participate in the APO project referred to on this form.Hospital/clinic name: Examiner’s name & title:Examiner’s signature: Date :Remarks, if any: |