



# විදේශ සම්පත් දෙපාර්තමේන්තුව வெளிநாட்டு வளங்கள் திணைக்களம் Department of External Resources

ජාතික ප්‍රතිපත්ති හා ආර්ථික කටයුතු අමාත්‍යාංශය  
මහලේකම් කාර්යාලය (3 වැනි මහල), නැ.අප. 277, කොළඹ 00100, ශ්‍රී ලංකාව  
தேசிய கொள்கைகள் மற்றும் பொருளாதார அலுவலகம் அமைச்சு.  
செயலகம் (3 ஆம் மாடி), ந. பெ. இல. 277, கொழும்பு 00100, இலங்கை

Ministry of National Policies and Economic Affairs  
The Secretariat, 3<sup>rd</sup> Floor, No. 277, Colombo 00100, Sri Lanka  
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Web Site: www.erd.gov.lk

මගේ අංකය  
எனது இல.  
My No

TA/CHI/S/1186

ඔබේ අංකය  
உமது இல.  
Your No. -

Imilin

29 MAR 2017

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திகதி  
Date

22-03-2017



Secretary\ Ministry of Health Nutrition & Indigenous Medicine  
Secretary\ Ministry of Provincial Councils & Local Government

Dear Sir/Madam

## 2017 Training Program on Technology of Traditional Chinese Medicine for the Key Cooperation Countries of Developing Countries from 12<sup>th</sup> April to 10<sup>th</sup> July 2017 - China

The Government of China has invited nominations from eligible Government Officials in Sri Lanka for the above training programme. The officials who attended for a training programme funded by the Chinese Government in 2016 are not entitled to apply for this training programme.

Therefore, you are kindly requested to submit nominations from all provinces along with the following documents (in 2 sets) **as soon as possible**.

1. Duly filled Application Form, along with the copies of the nominee's academic and professional qualifications.
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 Application Form, ERD Form 2 and the Medical Report in this regard are enclosed.

Your early response in this regard is highly appreciated.

Yours sincerely

Noor Rizna Anees  
Additional Director General  
for Director General

DCS/PRF  
2017  
Forwarded Please  
For Chief Secretary

PST closing Date  
03/04/2017

Copies to: **Chief Secretaries, All Provincial Councils**  
**Director General, Department of Ayurveda**  
**Directors, Ayurvedic Teaching Hospitals**

## 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				
<p>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?                      (Each item must be answered "Yes" or "No")</i></p>						
斑疹伤寒 Typhus fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	细菌痢 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					
流行性脑脊膜炎 Epidemic cerebrospinal meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes					
<p>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?                      (Each item must be answered "Yes" or "No")</i></p>						
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 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：  <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 border="0"> <tr> <td>霍乱</td> <td>Cholera</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>性病</td> <td>Venereal Disease</td> <td><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																									

### Applicant Personal Information

Seminar name:

Name		Institute	Levle	Passport No.	Birthday	Expired date	Nation nality	sex
Family Name	Given Name							

Note: Please send the electronic version