TUNG LING BIBLE SCHOOL

CERTIFICATE OF HEALTH

2 Gambas Crescent, #10-04/05, Nordcom II, Singapore 757044
Tel: 6345 4353 Fax: 6345 4639
Email: admin@tungling.org.sg
Website: www.tungling.org.sg

Applicant: This Health Certificate is a requirement for all foreign students. This is to be submitted in English, hand-signed and certified by your physician, on this Tung Ling Bible School official form only and must be received as soon as possible. Kindly email the completed form, dated and signed/certified by your physician to admin@tungling.org.sg or fax to (65) 6345 4639 and bring the original with you to the school. Thank you for your co-operation.

School of Ministry Term☐1 / 2☐ Year _____ School of Leadership Year _____

Section A - *Personal Information*

_____ Date of Birth____/____/_____ Gender: ❑ M ❑ F
Name (as in the passport) Day Month Year

_____
Address Country

For Women Applicants Only

State whether you are pregnant ☐ No ☐ Yes

(Should you become pregnant before your scheduled arrival date, your application will be deferred.)

Physical Examination – *To be completed by a Medical Doctor*

Height: _____ Weight: _____ Blood Pressure: Systolic _____ Diastolic _____

Please indicate (mark with ✓) if the applicant has suffered any of the following:

Asthma	❑	Malaria	❑	Skin Disease	❑	Hypertension	❑
Diabetes	❑	Epilepsy	❑	Heart Disease	❑	HIV+/AIDS	❑
Gout	❑	Tuberculosis	❑	Blood Disorder	❑	Mental Disorder	❑
Gastric disorder	❑	Cancer/Tumour	❑	Sleep Disorder	❑	(Eg. depression, schizophrenia)	

If yes, please explain the medical disease and state the present condition and treatment:

_____

_____

_____

Continued on next page

Hearing: Normal ❑ Abnormal ❑ Explain_____

Vision: Normal ❑ Glasses ❑ Contact Lenses ❑ Explain_____

_____ _____

Physical Disabilities/Deformities Diet Restrictions

_____

Surgery (if any) and Date of Surgery

_____

List Medications or Drugs Required

Any further comments _____

_____

_____

_____

_____

Physician's Declaration

I certify that I have examined the candidate_____ and certify that he/she is medically fit to travel and attend the 3-month School of Ministry /3-month School of Leadership * course in Singapore.

_____ _____

Name of Doctor and Qualifications Official Stamp

_____ _____

Address Postal Code, Country Telephone

Doctors Signature _____ Date _____

** delete where applicable*