



**TUN TAN CHENG LOCK
COLLEGE OF NURSING
ASSUNTA HOSPITAL**

APPLICATION FORM for DIPLOMA in NURSING

Please tick (✓) where appropriate.

I'm interested in: Scholarship Self Sponsor

Kind attach
coloured passport-
sized photograph.

A. PERSONAL DATA

Name (as per I/C) : _____
 NRIC No. : _____
 Gender Male / Female _____
 Status Single / Married / Divorced / Widowed _____
 Date of Birth : _____ Age : _____ Place of Birth : _____
 Ethnicity : _____ Religion : _____ Nationality : _____
 Correspondence : _____
 Address : _____

Contact House : _____ H/P : _____ Email : _____

B. FAMILY DATA

Father's Name : _____ Age (if living) : _____
 Religion : _____
 Father's Occupation Present : _____
 Past : _____
 Mother's Name : _____ Age (if living) : _____
 Religion : _____
 Mother's Occupation Present : _____
 Past : _____

Parent's Relationship Good Separated Divorced Widowed

Total no. of children in family including yourself : _____
 No. of brothers : _____ No. of sisters : _____ Your position in the family : _____

No	Name of Siblings	Age	Occupation	Employer

C. MEDICAL HISTORY

Health status of parents (if ill, describe nature of illness)
 Father / Mother : _____
 Health status of siblings (specify nature of illness, if any) : _____
 Have you been admitted to a hospital before? Yes No
 If yes, please specify. Age Reason for Hospitalisation
 (a) _____
 (b) _____
 (c) _____

Do you have any physical disability? Yes No

If yes, please describe. _____

What is your Height? (in cm) _____ Weight? (in kg) _____

Please tick (✓) where appropriate.

	<u>YES</u>	<u>NO</u>
Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>
Sight problem	<input type="checkbox"/>	<input type="checkbox"/>
Speech defect	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells / fainting attacks	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fits	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on any medical treatment / medications?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify. _____

D. EDUCATIONAL QUALIFICATIONS

<u>School / College</u>	<u>Year start / end</u>	<u>Certificate / Diploma</u>	<u>Grade obtained</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Membership in Clubs, Societies or Organisations _____

Hobbies and special interest _____

Have you attended any courses in another College / University? Yes No

If yes, please specify. _____

Do you have any professional training? If yes, please specify. _____

Do you have any previous disciplinary misconduct or have you been convicted of any offenses?

Yes Kindly describe. _____
No _____

Details of Examination Results

Certificate	Results			
		<u>Grade</u>		<u>Grade</u>
Penilaian Menengah Rendah (PMR) YEAR: _____	B. Malaysia English Mathematics Science	_____ _____ _____ _____	Other subjects _____ _____ _____	_____ _____ _____ _____
Sijil Pelajaran Malaysia (SPM) YEAR: _____	B. Malaysia English Mathematics Add Maths Accounts Basic Economics General Science Biology	_____ _____ _____ _____ _____ _____ _____ _____	Chemistry Physics Other subjects _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
Sijil Tinggi Pelajaran Malaysia (STPM) YEAR: _____	Pengajian Am B. Melayu Mathematics Add Maths Accounts Economics Science	_____ _____ _____ _____ _____ _____ _____	Biology Chemistry Physics Other subjects _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____

Please attach copies of:
 STPM, SPM, PMR Results
 NRIC (I/C)
 Birth Certificate
 Testimonials

*Note: Attaching Certificate of Participation in school extra-curricular activities will be favourably looked upon.

E: WORKING EXPERIENCE

Have you worked before? Yes No

Position _____	Employer _____	Duration _____
Position _____	Employer _____	Duration _____
Position _____	Employer _____	Duration _____

F. GENERAL INFORMATION

Language Proficiency

Please tick (✓) where appropriate.

	<u>Average</u>	<u>Good</u>	<u>Excellent</u>
Spoken			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

