THE BIBLE COLLEGE OF WALES
An extension of CCCW

CERTIFICATE OF HEALTH

Applicant: This Health Certificate is a requirement for non UK citizens. This is to be submitted in English, hand-signed and certified by your physician, on this Bible College of Wales official form only and must be received together with your application. Alternatively, you may choose to submit a personal health report that is within a validity of one year. Kindly email the completed form, dated, signed/certified by your physician to ***registration_som@bcwales.org*** *and mail the original copy to the Bible School. Thank you for your cooperation.*

☐ Semester 1 (Mar – May)   Year ______________   Date of Application ________________

OR

☐ Semester 2 (Sep – Nov)

PERSONAL INFORMATION

Name (as in passport) ____

Gender ☐ M ☐ F   Date of Birth: ____/____/____ (DD/MM/YY)

Home Address ____

Country _________________

FOR WOMEN APPLICANTS ONLY

State whether you are pregnant ☐ Yes ☐ No

(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/Tumor	☐ Sleep Disorder	(Eg. Depression, schizophrenia)

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

____

____

Hearing: ☐ Normal ☐ Abnormal   Explain: ____

Vision: ☐ Normal ☐ Glasses ☐ Contact Lenses Explain: ____

Physical Disabilities/Deformities: ____

Diet Restrictions: ____

Surgery (if any) and Date of Surgery: ____

List of Medications or Drugs required: ____

Any further comments:

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____
____
____
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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 Bible College of Wales course in the UK.

______________________________ ______________________________
Name of Doctor and Qualifications Official Stamp

____ ______________________________
Address Country Telephone

______________________________ ______________________________
Doctor's Signature Date

*Scan and Email the Certificate of Health form to **registration_som@bcwales.org**

*Mail out the original copy to the following address:

The Registrar
Bible College of Wales
Derwen Fawr House
Derwen Fawr Road
SA2 8EB Swansea
United Kingdom