

Application Document Checklist

Please avoid handwriting through the entire application form except for the signature.

- ❖ Please mark “✓” in the space after confirming the required documents.
- ❖ Please submit all the required documents to oisa.npust@gmail.com
- ❖ The diploma and transcript must be authenticated by the [Taiwan Embassy/ Mission](#) in the country of the issuing school before enrollment. If the original document is neither in English nor Chinese, a certified copy in English or Chinese is required.

Mark “✓”	Required Documents
	入學申請表 Completed School Admission Application Form
	推薦信二封 2 Recommendation Letters
	研究計畫書 Research Plan
	聲明書 Letter of Declaration
	健康聲明書 Health Statement
	最高學歷畢業證書 Highest Diploma (Certification of Graduation)
	最高學歷成績單及分數值量表 Official Transcript and Score Chart (Grading Scale) of Highest Degree
	英文能力證明（英語系國家申請者除外） Evidence of English Proficiency (excluding applicant whose native language is English)
	護照個人資料頁 Passport's Personal Information Page
	其他相關文件（論文發表） Other Supporting Documents Related to the Application (Publications)
	國合會獎學金線上申請表 Online Application System (icdf.org.tw) Completed TaiwanICDF Scholarship Online Application Form Online Application System (icdf.org.tw)



School Admission Application Form

Project Title: TaiwanICDF International Higher Education Scholarship Master and Ph.D. Programs on Tropical Agriculture

This form should be completed in regular font by the candidate. Each question must be answered clearly and completely. Details are required in order to make appropriate arrangements. If necessary, additional pages of the same size may be attached.

Mark the appropriate scholarship program listed as follows:

- Master Program in Tropical Agriculture
 Ph.D. Program in Tropical Agriculture

1. Personal Data

Name	First name: Middle name: Family name: Name in Chinese (if available):	*Attach Recent Photograph Here																							
Contact Information (Apply to Phone Interview)	Home Address (permanent): Mailing Address: E-mail: Tel (home): (country code) Tel (mobile): (country code)																								
Nationality	Country: _____ / Official Language: _____																								
English Proficiency (please ✓ in the appropriate boxes)	Listening Reading Writing Speaking																								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">Excellent</td> <td style="width: 12.5%;">Good</td> <td style="width: 12.5%;">Fair</td> <td style="width: 12.5%;">Excellent</td> <td style="width: 12.5%;">Good</td> <td style="width: 12.5%;">Fair</td> <td style="width: 12.5%;">Excellent</td> <td style="width: 12.5%;">Good</td> <td style="width: 12.5%;">Fair</td> <td style="width: 12.5%;">Excellent</td> <td style="width: 12.5%;">Good</td> <td style="width: 12.5%;">Fair</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Excellent	Good	Fair	Excellent	Good	Fair	Excellent	Good	Fair	Excellent	Good	Fair												
Excellent	Good	Fair	Excellent	Good	Fair	Excellent	Good	Fair	Excellent	Good	Fair														
Date of Birth	(DD/MM/YYYY)																								
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married																							
Religion		Health Condition																							
Chronic Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify:																								
Dietary Restriction	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify:																								

Contact Person in Emergency	Name:
	Relationship:
	Address:
	Tel:
	E-mail:

2. Present Employment

Designation/Title		Since DD/MM/YYYY
Institute/Organization		
Type of Business		
Address	Tel:	
	Fax:	
Type of the Organization	<input type="checkbox"/> Govt. Ministry/Agency <input type="checkbox"/> Govt./State Owned Enterprise <input type="checkbox"/> Joint Venture <input type="checkbox"/> NGO	<input type="checkbox"/> University/Institution <input type="checkbox"/> Locally Owned Enterprise <input type="checkbox"/> Foreign Owned Enterprise
Present Job Duties		

3. Previous Working Experience

Designation/Title	Organization	Period Of Employment	Job Duties

4. Education and Training

Note: Highest Diploma Only

Qualifications	Department	School Name	Country	Year Obtained (Christian era)
<input type="checkbox"/> Bachelor <input type="checkbox"/> Master <input type="checkbox"/> Other: _____				
Grade Point Average (GPA)/ Full Marks		/		

5. Recommendation Letters (Contact Person)

Name	Title (Position)	Institute
1.		
2.		

* The inserted letters must match the list above, and please do not insert more than two (we will only use the first 2 matched letters for the paper review).

----- Please insert the recommendation letters after this page -----

Autobiography

A large, empty rectangular box with a thin black border, occupying most of the page below the title. It is intended for the user to write their autobiography.

Research Plan

Note: The study/research plan should include the following items in detail. Please use additional pages of the same size to attach the context.

- 1. Major Subject**
- 2. Project Title**
- 3. Introduction**
- 4. Objective**
- 5. Action Plans**
- 6. Anticipated Results**
- 7. References**

Letter of Declaration

1. I hereby declare that the information and documents as provided by me in the application form are true and accurate. I understand and accept that any false declaration of information on my part will disqualify me from the program, even when it is in progress.
2. I declare that I am not suffering from any serious or chronic disease and that I am not hindered in the performance of my duties by any illness or disability:
3. I hereby undertake to abide by the national laws during my stay in Taiwan and undertake to do the following:
 - 1.1 Fulfill due performance as required in attendance.
 - 1.2 Not seek employment or engage in any political activities.
 - 1.3 Bear any additional expenses or risks incurred as a result of any changes initiated by myself.
4. I fully agree that the TaiwanICDF has the right to terminate the scholarship if, during my stay in Taiwan, my behavior causes any difficulties for the management of the TaiwanICDF or the training institution.
5. I understand that during my stay in Taiwan, only those matters related to the training program will be settled in accordance with the Taiwanese/ NPUST's rules and regulations, and that the Taiwanese/ NPUST's decision will be final and will be implemented accordingly. Cases irrelevant to the training program shall be otherwise of my own responsibilities and at my own cost.

Name: _____ (Printed)

_____ (Signature)

_____ (DD/MM/YYYY)

Health Statement

Nationality: _____

Full Name: _____

Height: _____ cm

Weight: _____ kg

Health History:

Please mark in the appropriate boxes whether you have ever suffered any of the following conditions:

	Yes	No		Yes	No
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (PTB)	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (HPT)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus (DM)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (rubella)	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>			

Please State (if any):

Other illnesses:

Operation/Surgery:

Allergic to:

Family Medical History

(If any, please specify)

Father:

Mother:

Past Year Life (please select):

- How many hours do you sleep every day? 7 or more hours Under 7 hours Often suffer from insomnia
- If that is basic to exercise each time for 30 minutes and 3 times every week at least, did you achieve? Yes No
- Do you often feel anxious and worried? Yes Sometimes No
- Do you often feel the chest is stuffy? Yes Sometimes No
- Do you often feel stomachache? Yes Sometimes No
- Do you often feel headache? Yes Sometimes No