

F.No. 18/22/2004-PMU
Ministry of Finance
Department of Economic Affairs
(PMU & Training Division)

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New Delhi February 11, 2004

OFFICE MEMORANDUM

Subject: Training Programme during 2004 under USAID assistance – **Budgeting and Revenue Planning** in Global Training and Development Institute (formerly Institute of Public Service International) University of Connecticut, Hartford.-seeking of nominations regarding.

Global Training and Development Institute (formerly Institute of Public Service International) University of Connecticut, West Hartford, Connecticut is organizing a course on **Budgeting and Revenue Planning** under the Technical Assistance Support Project (TASP) under USAID from June 7 – July 2, 2004.

2. INTENDED AUDIENCE: Public sector finance officers and budget officials and policymakers from central, regional and local governments.

3. COURSE OBJECTIVES: The Budgeting Process, Capital Budgeting, Revenue Planning & Cash Management, Microcomputer Applications & the Internet.

4. Travel expenses, course fee (if any), daily allowance, etc. of Indian officials would be borne under USAID assisted Technical Assistance Support Project (TASP), as applicable.

5. You are requested that the nomination of a suitable officer may please be forwarded to this Department along with details in the enclosed proforma as early as possible, but not later than 3rd March, 2004. Incomplete application forms will not be considered. Nominated officers should also have valid passport.

6. Nominations of officers should be done with necessary clearances from their respective cadre controlling authorities.

7. Details including application forms can be downloaded from www.finmin.nic.in (Training Programmes/“Short courses in USA”).

Sd/-
(Samir Kumar)
DD (PMU & Trg)

To,

1. Secretary (Expenditure & Budget), Ministry of Finance, New Delhi.

2. Shri. R.K. Malhotra, Under Secretary, Department of Revenue, New Delhi.
3. Secretary (Finance) of all the State Governments.

Copy to Technical Director, NIC with a request to place it on Finance Ministry's website under "Short courses in USA."

PROFORMA FOR BIO-DATA

1.	Name of Applicant			
2.	Present Designation			
3.	Name of Service and the Cadre Controlling Authority			
4.	Present Pay Scale			
5.	Work Mailing Address, Telephone Number and Fax Number			
6.	Residential Address with Telephone Nos.			
7.	Date of Birth	<i>Date</i>	<i>Month</i>	<i>Year</i>
8.	Date of Superannuation			
9.	Years of Service Left* <i>* at the time of commencement of the training</i>			
10.	Educational Qualifications			
11.	Present Job Description (duties and responsibilities)			

12.	Previous Employment Background/Work Experience			
Name and Address of Employer	Job Title	From	To	Job Contents
13.	List out training attended in India/abroad			
Sl.No.	Dates & duration of training	Subject/Title of training	Name of the trg. Institution	Source of Funding
14.	Any Other Relevant Information			

(Full Signature of Candidate with date)

UNDERTAKING

I hereby undertake that I am committed to return to India after training programme on “-----” at ----- from ----- to ----- 2003 under USAID assisted Technical Assistance and Support Project.

(Signature/with name of applicant)

THE AGENCY FOR INTERNATIONAL DEVELOPMENT GUIDELINES FOR THE EXAMINING PHYSICIAN

All reports should be in the English language

PURPOSE OF EXAMINATION

The person you are authorized to examine to a condition for training under a USAID program. The United State Government decides to verify that person is physically and mentally fit to enter into a ----- training program and took that your examination identify any magnificent model condition which may require correction or model management exemption should be placed on those conditions that are likely to..... of the training or result in medical.

You should inform the candidate of any abnormal finding that requires ----- but need not inform the person on to the likelihood of ----- into the training programme until the forms have been revised by the USAID Training Office.

SCOPE OF THE EXAMINATION

The candidate should complete the first two pages which is a medical history about that person. After careful ----- you should perform your examination taking into considerations and commenting on any positive findings.

Laboratory tests should include in a minimum unanalysis blood Eurology . There may be a mood for conditional laboratory studies to compute your evaluation. However,

Eurology must be obtained from the USAID Training Office before obtaining those studies.

Blood samples to the examination form by listing defects or diagnosis after your recommendation no to the candidate a ability to enter into the complete the projected training program.

DISOPOSITION OF MEDICAL REPORT

The completed form should be sealed in the attached envelope and introduction followed with regard to thedisposition . All the form should be treated as medical confidential.

**THE AGENCY FOR INTERNATIONAL DEVELOPMENT
OFFICE OF INTERNATIONAL TRAINING
MEDICAL HISTORY AND EXAMINATION FOR FOREIGN APPLICANTS**

	Medical History to be completed by Applicant			
1.	Name of examinee (last name, first name, middle name)			
2.	Date of Birth (month/day/yr)	3. Nationality	4. Sex ----- male ----- female	5. Address for Contact
6.	Training Location (city, state, country) ----- -			
7.	Length of Training (weeks, months, years) ----- --			
8.	Estimated Date to begin Training (month/year) ----- -			
9.	<u>IMPORTANT NOTICE</u>			
	Before you complete the Medical History Questionnaire, you are hereby notified that:			
	USAID does not provide medical insurance for dependants who accompany the applicant.			
	A medical condition resulting from undisclosed pre-existing condition may not be financially compensated for by USAID and may result in termination of your training program.			
	I understand and accept the terms of this notice -----yes -----No			

10.	Applicant will check "YES" or "NO" and Explain		
	YES	NO	EXPLANATION
a.		Have you had any significant or serious illness or injury? (If ospitalized, give place & dates)	
b.		Have you had any operations or advised by a physician to have an operation? (give place & dates)	
c.		Do you currently use any drugs for treatment of a medical condition? (give name & dose)	
d.		Have you ever been a patient in a mental hospital or sanitarium or treated by a Psychiatrist? (give place & dates)	

11. APPLICANT WILL INDICATE "YES" ON "NO" TO EACH ITEM DO YOU NOW HAVE ON HAVE YOU EVER HAD TUE CONDITIONS LISTED BELOW?

	YES	NO	CONDITION
a.			Epilapsy, convulsions, "fits"
b.			Eye disease, vision defeat in both or either eye
c.			Tooth or gum disease (periodontal disease)
d.			Asthmam emphysema, or other lung conditions
e.			Tuberculosis or Live with anyone who has tuberculosis
f.			High blood pressure; heart disease
g.			Stomach, liver (haptitis), yallbladdar disease
h.			Hernia (rupture)
i.			Kidney or bladder disease, stone or blood in urine
j.			Diabetes (sugar in the urine)
k.			Joint disease or injury, swollen or painful joints
l.			Back pain, wear a back brace or support
m.			Tropical disease (malaria, bilharzias, amoabiasis, leprosy, filariasts, yaws, etc.)
n.			Depression, excess worry, attempted suicide, or other psychological symptoms
o.			Drug or narcotic habit such as marijuana, cocaine, heroin, LSD or any derivatives
p.			Bleeding disorder, blood disease (sickle cell anemia)
q.			Acquired Immune Deficiency Syndroma (AIDS)
r.			Tumor, abnormal growth, cyst, or cancer

s.			Skin, disorder, growths, psoriasis
t.			Female disorder (gynecological disease), abnormal menses
u.			Pregnant currently

I Certify that I have read the above instructions and answered all questions truly and completely to the best of my knowledge.

12. Printed name of Applicant	13. Date	14. Signature of Applicant
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Note:- For the examining physician, Please review this Medical History and make appropriate comments on the Examination form on all positive or significant documents

REPORT OF MEDICAL EXAM FOR POLITICS APPLICANT TO THE TO THE EXAMINING PHYSICIAN	PHOTO
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15. Name of Participant	
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16. Height	17. Weight	18. Blood Pressure	19. Corrected Vision L20:----- R20:-----
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20. Urinalysis (nutar, blood etc.)	21. Blood Serology test for Syphills positive ----- negative -----
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22. Pregnancy Test (ECG) (for female patients only) Positive ----- negative -----
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23. Chest X Ray Report (Date)	24. Electrocardiogram Report (If indented by history or physics)
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Normal	25. Clinical Evaluation	Abnormal	Describe Agholoial Findings
	Head, nose, Mouth		
	Ears, hearing		
	Eyes, Visual acuity		
	Lungs and chest		
	Heart, rhythm & sounds		
	Vasculor system, vari-cosities		
	Alxiomen, hernis, etc.		
	Hemorrhoids, listuin prostote		
	Urinary system		
	Spine, arms, legs etc.		
	Skin, lymph nodes, scars		
	Neurological		
	Emotional stability		

26. The Physician must comment or all Items haiured "YES" in the History and

comment on any condition discovered during the examination.

27. Summary of any defects and Diagnosis: Recommendations :
----- Medically Qualified for Training
-----Not Medically Qualified For Training

28. Examining Physician	29. Address	30. Date of Exam.
31. Signature of Examining Physician		
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**ADMINISTRATIVE REVIEW OF MEDICAL EXAMINATION
(FOR USE BY POST TRAINING OFFICE)**

Candidate Name -----

Medical Clearance Action:

Action by training Officer:

- Recommend approval of Applicant's entry into training program
- Recommend disapproval of Applicants entry into training program reason for rejection.

Date-----

Signature: -----

Printed Name: -----

Revised By
(Use Office Only)

Signature: -----

Printed Name: -----

Medical Halver Action

Application rejected for training of Medical Problems may be re-evaluated for training with a halver of H.A.C coverage for specified pre-existing condition.

The A.I.D. Mission may determine to grant a Halver when:

1. It is felt that the period of training will be of short duration and medical condition is unlikely to be activated or aggravated during that period or
2. The training is considered essential to the program objectives.

If a Halver is granted, the A.I.D. Mission accepts full responsibility to ensure payment of all claims arising from Halver conditions. This determination by the USAID Director of UB offician design must be obtained prior to further processing of the applicant.

Date-----

Signature: -----

Printed Name: -----

Position Title: -----

