



**D. QUALIFICATIONS**

Name of educational institute and centre	Certificates and/or diplomas obtained	ALL SUBJECTS. Underline major subjects. In the case of typing and shorthand, state languages and speed	Month and Year obtained
School	State highest qualification only	..... ..... ..... .....	
Universities, Colleges and other institutions	State all qualification	..... ..... ..... .....	
State field of further study (if any):			
Number of years apprenticeship successfully completed		Agreement No.	Institution
If your profession or occupation requires State or official Registration, state date and particulars of registration:			

**E. EXPERIENCE**

Employer	Post held	From			To			Reason for change
		Day	Month	Year	Day	Month	Year	
.....	.....	.....	.....	.....	.....	.....	.....	.....
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**F. CONTRACTUAL OBLIGATIONS**

Do you have any contractual obligations, e.a. study, military, bursaries, etc? (If so, describe)

.....

**G. DECLARATION**

I declare that the above particulars are complete and correct and I have not withheld any required information.

.....  
Signature Date

NOTE: A false declaration will disqualify your application or may lead to your discharge if discovered after your appointment.

**FOR OFFICIAL USE**

Particulars in B1 to 4, certified correct from Birth Certificate/ Identity Document

.....  
Signature Rank Date



**REPUBLIC OF NAMIBIA**

**HEALTH  
QUESTIONNAIRE**

THIS FORM MUST BE COMPLETED BY  
CANDIDATES FOR PERMANENT  
APPOINTMENT / TRANSFER IN THE  
GOVERNMENT SERVICE

FOR DEPARTMENTAL USE	
Accepted/ Rejected in accordance with directions	
..... Signature	
Date:	Rank:
Department:	

**A.**

1. Surname (in block letters)		Identity No.:	
2. First Names:			
3. Age	yrs.	4. Height:	cm
		5. Body mass:	kg

**B**

Are you suffering or have you ever suffered from:	Mark with an "X" in the appropriate column		If any answers is "Yes", give details of the nature, severity, date and duration of the illness
	Yes	No	
1. Any skin disease?			..... .....
2. Any affection of the skeleton and or joints?			..... .....
3. Any affection of the eyes, ears, nose or teeth			..... .....
4. Any affection of the heart or circulatory system?			..... .....
5. Any affection of the chest or respiratory system?			..... .....
6. Any affection of the digestive system?			..... .....

Are you suffering or have you ever suffered from:	Mark with an "X" in the appropriate column		If any answers is "Yes", give details of the nature, severity, date and duration of the illness
7. Any affection of the urinary system and / or genital organs?	Yes	No	..... .....
8. Any nervous affection or mental abnormality?	Yes	No	..... .....
9. Any other illness?	Yes	No	..... .....

**C**

	Yes	No
1. Do you suffer from any defect of hearing, speech or sight?		
2. Are you physically disabled and do you use artificial limbs?		
GIVE DETAILS OF THE NATURE AND SEVERITY OF THE DISABILITY:		

**D**

	Yes	No
Have you undergone any operation(s)?		
GIVE DETAILS OF THE NATURE AND DATE OF THE OPERATION(S):		

**E**

I declare that the above information is true and correct and that I have not withheld any information regarding my health.

.....  
Signature

.....  
Date