REPORT ON THE HEALTH STATUS OF PEOPLE UNDER THE ATTENTION OF THE GRANTEE
HUMAN CAPITAL DEVELOPMENT DEPARTMENT
NATIONAL AGENCY OF RESEARCH AND DEVELOPMENT
ANID

NOTE: ANID's Human Capital Development Department requires this information to evaluate a request made by the grantee regarding the health status of a person under his/her care. The complete, correct and truthful filling of this report provides information aimed to support a relevant decision. The accuracy of the information contained in this form is the sole responsibility of the interested party. Sections A and B shall be completed by the grantee. Sections C and D, by the physician

A. INFORMATION ABOUT THE GRANTEE	
GRANTEE'S NAME *	
NAME OF THE PERSON UNDER GRANTEE'S CARE *	
GRANTEE'S RUT NUMBER *	RUT OF PERSON UNDER GRANTEE'S CARE *
GRANTEE'S CURRENT ADDRESS *	
GRANTEE'S PHONE NUMBER *	GRANTEE'S CITY/COUNTRY *
PROGRAM *	
UNIVERSITY *	

B. SIGNATURE OF HEALTH DECLARATION*

I hereby confirm that the information provided in this health declaration is accurate and true and, after revision of this document, I certify that the information is complete.

I authorize the Human Capital Development department to use this information, with the exclusive purpose of evaluating the health status of people under my care in order to analyze a request that I made.

Grantee Signature

Date (Grantee Handwriting)

*Required field

B. PHYSICIAN BACKGROUND*	
PHYSICIAN'S NAME AND HEALTH INSTITUTION*	
PHYSICIAN'S PHONE NUMBER*	PHYSICIAN'S E-MAIL*

C. MEDICAL DIAGNOSIS*

ATTENTION

PLEASE READ AND COMPLETE ACCURATELY THE QUESTIONS BELOW: INFORM ANY ILLNESS, DISEASE OR HEALTH CONDITION ACCORDING TO YOUR MEDICAL DIAGNOSIS OF THE PATIENT, DETAIL THE TREATMENT, EVENTUAL HOSPITALIZATION OR SURGICAL INTERVENTION, INDICATE THE DATE OF DIAGNOSIS AND HIS/HER CURRENT STATUS, THE ESTIMATED TIME OF RECOVERY AND DISCHARGED.

THIS LIST IS ONLY REFERENTIAL; THEREFORE IF THE PATIENT HAS HAD ANOTHER DISEASE NOT LISTED HERE, PLEASE DECLARE IT.

TIPOLOGY OF MEDICAL DIAGNOSIS (indicate the diagnosed diseases)		
1	Menthal/Psychiatric or behavioral disease	
2	Nervous system disease	
3	Respiratory system disease	
4	Heart and circulatory system disease	
5	Digestive system disease	
6	Gynecologic and breast disease	
7	Renal or genito-urinary system disease	
8	Osteo-muscular system or rheumatologic disease	
9	Blood or hematopoietic system disease	
10	Endocrine, nutritional and metabolic disease	
11	Tumor or cancer disease	
12	Skin and subcutaneous tissue disease	
13	Ear, nose and throat disease	
14	Eye disease	
15	Infectious and parasitic disease	
16	Pregnancy, childbirth or puerperium disease	
17	Traumatism, accident and burn	
18	Another disease (detail)_____	

SPECIFIC MEDICAL DIAGNOSIS (Please detail the medical diagnosis of the patient)*

DIAGNOSIS DATE *:

*Required field

SURGERY REQUIRED?	YES		NO
THE SURGERY IS :	AMBULATORY		EXTENDED
APPROXIMATE DATE OF SURGICAL INTERVENTION			
DOES THE PATIENT REQUIRE REST?	NO	SOME REST	ABSOLUTE REST
REST PERIOD	FROM (dd/mm/yy)		TO (dd/mm/yy)
MEDICAL LEAVE REQUIRED?*	NO	PARTIAL	TOTAL
MEDICAL LEAVE PERIOD (IF MEDICAL LEAVE REQUIRED, MUST INDICATE PERIOD):	FROM (dd/mm/yy)		TO (dd/mm/yy)
WHETHER YOU CONSIDER THE DISEASE OF THE PERSON UNDER THE GRANTEE'S CARE PREVENTS HIM/HER FROM STUDYING AND CARRYING OUT ACADEMIC ACTIVITIES?*	NO	PARTIALLY	TOTALLY
INDICATE PERIOD IN WHICH HEALTH CONDITION OF THE PERSON UNDER THE GRANTEE'S CARE PREVENTS HIM/HER FROM STUDYING AND CARRYING OUT ACADEMIC ACTIVITIES*	FROM (dd/mm/yy)		TO (dd/mm/yy)
ESTIMATED RECOVERY OR MEDICAL DISCHARGE DATE (Please detail period and date):			
HAS THE PATIENT BEEN TREATED FOR THE SAME CAUSE BEFORE? (Indicate and detail date)			
HAS THE PATIENT HAD PREVIOUS MEDICAL LEAVE FOR THE SAME DIAGNOSIS? (Indicate and detail period)			
DID THE PATIENT UNDERGO PREVIOUS HOSPITALIZATIONS FOR THE SAME DIAGNOSIS? (Indicate and detail period)			

D. PHYSICIAN STATEMENT*
IMPORTANT COMMENTS THAT YOU WANT TO ADD:
After revision of this declaration of health, I hereby certify that information provided is accurate and complete. Signature and stamp of treating physician Institution: Hospital/Clinic Date

*Required field