HEALTH STATUS REPORT OF GRANTEE'S PEOPLE UNDER CARE
HUMAN CAPITAL DEVELOPMENT DEPARTMENT
NATIONAL AGENCY OF RESEARCH AND DEVELOPMENT
ANID

NOTE: The content of this report supports grantee's people under care health status and is part of the analysis of the request. Therefore, it must be filled, correctly and truthful 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, D and E, by the physician.

A. GRANTEE'S INFORMATION (*)	
GRANTEE NAME (*)	
RUT NUMBER (*)	
NAME OF THE PERSON UNDER GRANTEE'S CARE	
RUT OF PERSON UNDER GRANTEE'S CARE	
GRANTEE'S E-MAIL (*)	
GRANTEE'S PHONE NUMBER (*)	
GRANTEE'S CURRENT ADDRESS (*)	
GRANTEE'S CITY / COUNTRY (*)	
UNIVERSITY (*)	
PROGRAM (*)	

B. SIGNATURE OF THE 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 my health status to analyze a request that I made.	
Grantee signature (*)	Date (DD-MM-YYYY) (*)

Mandatory required field (*)

C. PHYSICIAN BACKGROUND (*)	
PHYSICIAN NAME (*)	
PHYSICIAN RUT (ONLY IF PRACTICE IN CHILE) (*)	
HEALTH INSTITUTION (*)	
PHYSICIAN E-MAIL (*)	
PHYSICIAN PHONE NUMER (*)	

D. MEDICAL DIAGNOSIS (*)	
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 ITS CURRENT STATUS, THE ESTIMATED TIME OF RECOVERY AND DISCHARGED. THIS LIST IS ONLY REFERENTIAL; THEREFORE, IF THE PATIENT HAD ANOTHER DISEASE NOT LISTED HERE, PLEASE DECLARE IT.	
TIPOLOGIA DEL DIAGNOSTICO MEDICO (marque la/s enfermedad/es diagnosticada/s)	
1) Mental or psychiatric or behavioral illness	
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 and the 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 the puerperium disease	
17) Trauma, accident and burn	
18) Another disease (detal):	
SPECIFIC MEDICAL DIAGNOSIS (*) (Please detail the medical diagnosis of the patient)	
DIAGNOSIS DATE (DD-MM-YYYY) (*):	

Mandatory required field (*)

WHETHER YOU CONSIDER THE DISEASE OF THE PERSON UNDER THE GRANTEE'S CARE PREVENTS HIM/HER FROM STUDYING AND CARRYING OUT ACADEMIC ACTIVITIES?? (*) (mark your choice)	TOTALLY	IT DOESN'T
INDICATE PERIOD IN WHICH HEALTH CONDITION OF THE PERSON UNDER THE GRANTEE'S CARE PREVENTS HIM/HER FROM STUDYING AND CARRYING OUT ACADEMIC ACTIVITIES (*) (exact range)	FROM (DD/MM/YYYY):	UNTIL (DD/MM/YYYY):
ESTIMATED RECOVERY OR MEDICAL DISCHARGE DATE (*) (Please detail period and date) (DD-MM-YYYY)		
HAS THE PATIENT BEEN IN TREATMENT FOR THE SAME CAUSE BEFORE? (*) (Explain and detail date) (DD-MM-YYYY)		

E. 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 the treating physician (*)	Date (DD-MM-YYYY) (*)

Mandatory required field (*)