HEALTH STATUS REPORT
HUMAN CAPITAL DEVELOPMENT DEPARTMENT
NATIONAL AGENCY OF RESEARCH AND DEVELOPMENT
ANID

NOTE: ANID's Human Capital Development Department requires this information to evaluate the request made by the grantee regarding his/her health status. 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 treating physician.

A. INFORMATION ABOUT THE GRANTEE	
GRANTEE NAME *	
RUT NUMBER.*	E-MAIL*
CURRENT ADDRESS *	
PHONE NUMBER*	COUNTRY/CITY*
PROGRAM*	
UNIVERSITY *	

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 in order to analyze a request that I made.

Grantee Signature) Date (Grantee handwriting)

*REQUIRED FIELD

B. PHYSICIAN BACKGROUND*	
PHYSICIAN NAME, HEALTH INSTITUCION*	
PHYSICIAN PHONE NUMBER *	PHYSICIAN E-MAIL*

C. MEDICAL DIAGNOSTIC*

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 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.

TIPOLOGY OF THE MEDICAL DIAGNOSIS (indicate the diagnosed disease(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 (detail)_____	

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

DIAGNOSIS DATE:*

*REQUIRED FIELD

DOES IT REQUIRE SURGERY?	YES		NO
THE SURGERY IS:	AMBULATORY		EXTENDED
APPROXIMATE DATE OF THE INTERVENTION PROCEDURE			
DOES THE PATIENT REQUIRE REST?	NO	SOME REST	ABSOLUT REST
REST PERIOD	FROM (dd/mm/yy)		UNTIL (dd/mm/yy)
REQUIERE MEDICAL LEAVE?	NO	PARTIAL	TOTAL
MEDICAL LEAVE PERIOD (IF IT REQUIRES MEDICAL LEAVE MUST INDICATE PERIOD)	FROM (dd/mm/yy)		UNTIL (dd/mm/yy)
¿WHETHER YOU CONSIDER THE DISEASE PREVENTS FROM STUDYING AND CARRYING OUT ACADEMIC ACTIVITIES?*	IT DOESN'T	PARTIALLY	TOTALLY
INDICATE PERIOD IN WICH HEALTH CONDITION PREVENTS FROM STUDYNG AND CARRYING OUT ACADEMIC ACTIVITIES*	FROM (dd/mm/yy)		UNTIL (dd/mm/yy)
ESTIMATED RECOVERY OR MEDICAL DISCHARGE DATE:(Please detail period and date)			
HAS THE PATIENT BEEN IN TREATMENT FOR THE SAME CAUSE BEFORE? (Explain and detail date)			
HAS THE PATIENT HAD PREVIOUS MEDICAL LEAVE FOR THE SAME DIAGNOSIS? (Explain and detail date)			
HAVE THE PATIENT HAD PREVIOUS HOSPITALIZATIONS FOR THE SAME DIAGNOSIS? (Explain and detail date)			

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 the treating physician Institution: Hospital/Clinic Date

*REQUIRED FIELD