

APPLICATION FOR RESEARCH/THESIS ADVISORSHIP



NUCLEAR TRAINING CENTER
 PHILIPPINE NUCLEAR RESEARCH INSTITUTE
 Commonwealth Avenue, Diliman, Quezon City
 Telephone No.: 929-60-11 to 19 local 236
 Email: ntc@pnri.dost.gov.ph

<i>Other Requirements to be submitted with this Application Form</i>	<i>Research/ Thesis</i>	Recent 1" x 1" ID picture
(i) Recommendation from School thesis adviser with endorsement by authorized school official	✓	
(ii) Agreement Form (Should be Notarized) (3 copies)	✓	
(iii) Confidentiality Undertaking (3 copies)	✓	
(iv) Thesis/ Research Abstract (1 copy)	✓	
(v) Memorandum of Agreement (notarized after being signed by PNRI Director, 3 copies)	✓	

Name: _____ Sex: Male Female
Surname First Name Middle Name

Civil Status: _____ Date of Birth: _____ Place of Birth: _____

Address: _____

Email Address: _____ Contact No.: _____

School/Institution: _____

Course: _____ Year Level: _____

Dean/Principal of School: _____

Email Address: _____ Contact No.: _____

Proposed Field of Research: _____

Proposed Research Activities:

Major Research Activities	Target Date of Implementation
_____	_____
_____	_____
_____	_____

Signature of Applicant

Conforme: _____
Research/Thesis Adviser at PNRI

Recommending Approval:

ROEL A. LOTERIÑA
 Head
 Nuclear Training Center

Approved:
CARLO A. ARCILLA, PHD
 Director

Do not write below the line (for NTC use only):

Name of Research/Thesis Adviser: _____ Section/Division: _____
 Arranged by: _____ Date: _____

MEDICAL CERTIFICATE

NOTE: To be completed by a registered medical practitioner after thorough clinical and laboratory examination including chest x-ray.

Name of Candidate

Sex

Status

Is the person examined at present in good health and enjoying full work capacity?

Is the person examined able physically and mentally to undergo training?

Is the person examined free from infectious diseases that could present risks for both the candidate and his contacts during his training?

Does the person examined have any condition or defect that might require treatment during his training?

Full Name, Address, and License Number of Examining Physician

Date

Signature of Examining Physician