

**ПОСОЛЬСТВО ЯПОНИИ
В КЫРГЫЗСКОЙ РЕСПУБЛИКЕ**

**КЫРГЫЗ РЕСПУБЛИКАСЫНДАГЫ
ЯПОНИЯНЫН ЭЛЧИЛИГИ**

720040, Кыргызская Республика, г.Бишкек, ул. Раззакова 16, Тел.: (+996-312) 300050/51, Факс: (+996-312) 300052, japanembassy@be.mofa.go.jp

МК - 022

30 октября 2020 года

Посольство Японии в Кыргызской Республике свидетельствует свое уважение Министерству здравоохранения Кыргызской Республики и имеет честь направить формы заявок на участие по курсу «Medical Administration» в рамках Программы Правительства Японии «Young Leaders' Program» на 2021 год.

В этой связи Посольство просит Министерство предоставить до 27 ноября 2020 года рекомендательное письмо с указанием списка кандидатов и заполненными документами, которые прилагаются к данной ноте.

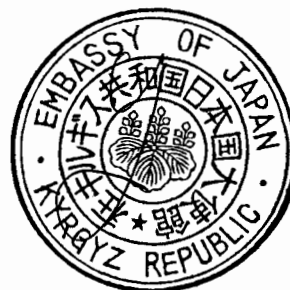
Посольство пользуется случаем, чтобы возобновить Министерству уверения в своём высоком уважении.

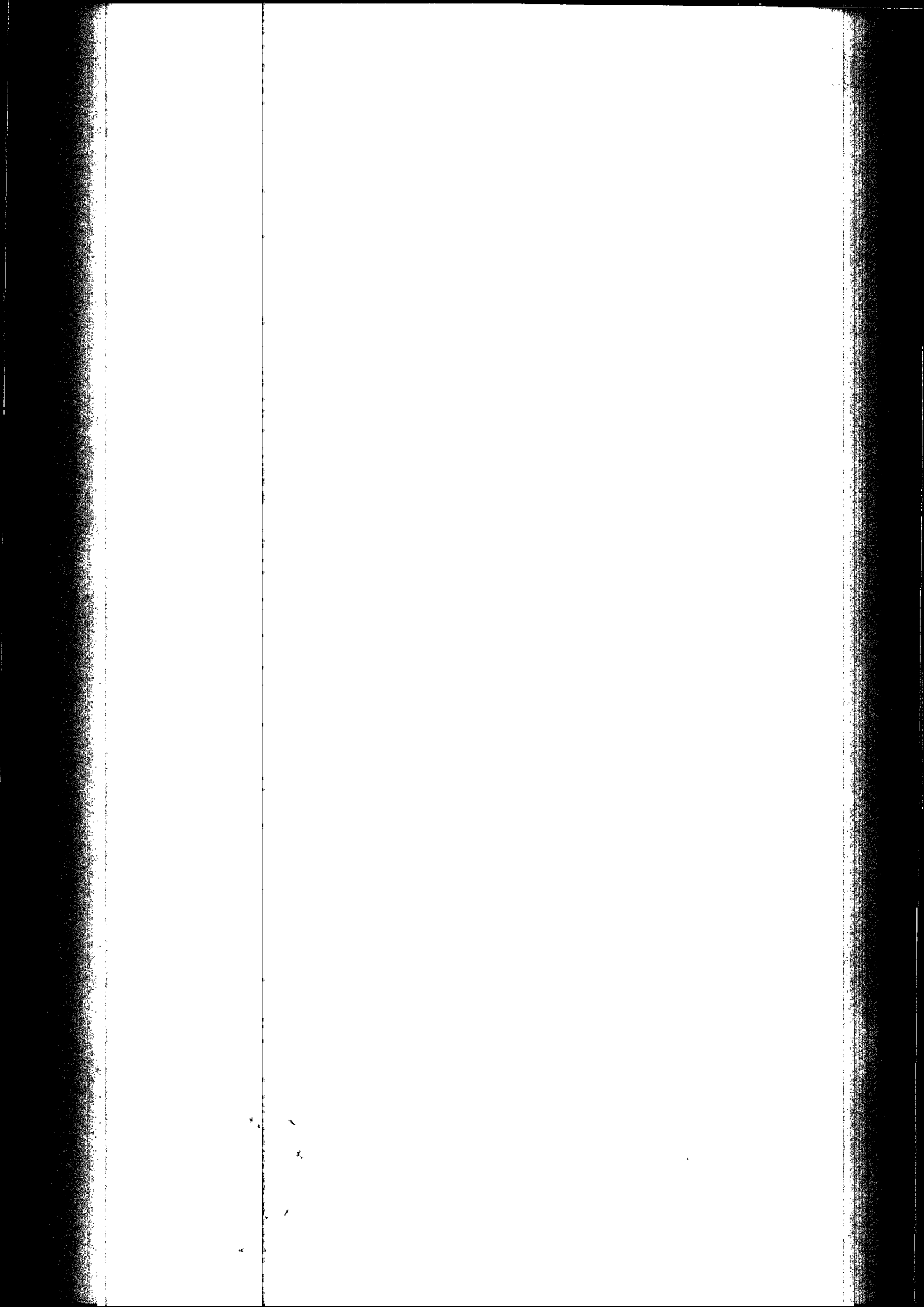
- Приложение:**
1. Форма заявки
 2. Сертификат о здоровье
 3. Форма рекомендации
 4. Руководство к Программе

**МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ
КЫРГЫЗСКОЙ РЕСПУБЛИКИ**

**КОПИЯ:
МИНИСТЕРСТВО ИНОСТРАННЫХ ДЕЛ
КЫРГЫЗСКОЙ РЕСПУБЛИКИ**

Кыргыз Республикасынын Ич Саламаттык сактоо министрлигинин Иш кагаздары жана уюштуруу иштери бөлүмү		
Отдел делопроизводства и организационной работы Министерства здравоохранения Кыргызской Республики		
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APPLICATION GUIDELINES
JAPANESE GOVERNMENT (MEXT) SCHOLARSHIP FOR 2021
YOUNG LEADERS' PROGRAM (YLP) STUDENT (HEALTHCARE ADMINISTRATION)

I OUTLINE

1. Objectives

The Young Leaders' Program (YLP) aims to contribute to cultivate future national leaders in Asian and other countries, moreover, to contribute to establish friendly relationship among various countries and to improve policy planning activities by forming a network among national leaders through deepening their understanding of Japan. The YLP is one of the Japanese Government (MEXT*) Scholarship Programs.

*MEXT: Ministry of Education, Culture, Sports, Science and Technology

2. Eligible Countries and Participants

Participants are selected from the countries listed below. They should be young public administrators in healthcare and allied sectors who are expected to play active roles as future national leaders in their respective countries.

Afghanistan, Bangladesh, Cambodia, Indonesia, Kazakhstan, Kyrgyzstan, Laos, Malaysia, Mongolia, Myanmar, Thailand, Uzbekistan, Vietnam (13 countries in alphabetical order)

3. Host University

Department of Healthcare Administration, Nagoya University Graduate School of Medicine

4. Expected number of students

Approximately 10 students

5. Recruitment and Selection

(1) Recruitment

Recruitment will be conducted through recommending authorities in the respective countries. Please contact the Japanese embassy in your country for further information.

(2) Screening Procedure

- ① First screening by the recommending authorities of each country
- ② Second screening by host university based on application documents
- ③ Third screening through interviews of candidates, conducted by faculty members of host university
- ④ Primary selection based on total scores of the second and third screenings along with comments of interviewers
- ⑤ Final selection by the YLP committee established by MEXT

6. Program Outline (Refer to the appendix "Curriculum Guidelines".)

(1) Basic Concepts

The curriculum is suitable for rearing national leaders in the field of healthcare administration, seeking to take advantage of Japan's experiences of exchange with both Western and Asian countries, and establish a human network through various activities such as special lectures and field study trips/site visits.

(2) Duration and Degree Conferred

Course duration is one year. Master of Science in Health Care Administration is conferred by Nagoya University Graduate School of Medicine.

(3) Medium of instruction

All lectures and academic activities are conducted in English.

7. Commencement of the Program

October 2021

IV Further Information

For further information on Nagoya University's Young Leaders' Program:

<http://en.nagoya-u.ac.jp/>

https://www.med.nagoya-u.ac.jp/medical_E/laboratory/basic-med/social-science/ylp/

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Should include:

1. Your background, important achievements in your field, and how they apply to the Young Leaders' Program
2. What are the most significant lessons you have learned from your experience?
3. How will this course help you achieve your goals?
4. What experience do you have in leadership?

IV Further Information
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<http://en.nagoya-u.ac.jp/>
https://www.med.nagoya-u.ac.jp/medical_E/laboratory/basic-med/social-science/ylp/

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健康診断書 (2021年度版)

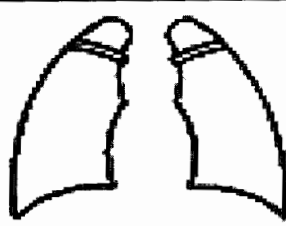
(医師に記入してもらうこと)
日本語又は英語により明瞭に記載すること。

CERTIFICATE OF HEALTH (for 2021)

(to be completed by the examining physician)
Please fill out (PRINT/TYPER) in Japanese or English.

氏名 Name	Surname 姓	Given name 名	Middle name ミドルネーム
性別 Gender	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	生年月日 Date of Birth	年 月 日 yyyy mm dd

1. 身体検査 Physical examination			
(1)身長 Height	cm	(2)体重 Weight	kg
(3)血圧 Blood pressure	mmHg~ mmHg	(4)血液型 Blood type	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> RH+ <input type="checkbox"/> RH-
(5)脈拍 Pulse	<input type="checkbox"/> 整 Regular <input type="checkbox"/> 不整 Irregular	(7)色覚異常の有無 Color blindness	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
(6)視力 Eyesight	裸眼 (右) (左) Without glasses (R) (L)	(8)聴力 Hearing	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
	矯正 (右) (左) With glasses or contact lenses (R) (L)	(9)言語 Speech	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired

2. 胸部聴診及びX線検査 (6ヶ月以内) Physical and X-ray examinations of the chest (within six months)			
	胸部X線所見 Describe the condition of lungs.	撮影年月日 Date of X-ray	年 月 日 yyyy mm dd
		フィルム番号 Film No.	
		(1)肺 Lungs	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		(2)心臓 Cardiomegaly	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		異常がある場合⇒心電図 If impaired⇒Electrocardiograph	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired

3. 現在治療中の病気 Disease currently being treated	<input type="checkbox"/> 無 No <input type="checkbox"/> 有 Yes : 病名 Disease
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4. 既往症 Past illness/disorder	✓	病名 Name	完治時期/治療中 Date of recovery /under treatment	✓	病名 Name	完治時期/治療中 Date of recovery /under treatment
該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。 Please check and fill in the date of recovery/under treatment. If NOT contracted any of them in the past, please check "None".		結核 Tuberculosis			マラリア Malaria	
		その他感染症 Other communicable disease			てんかん Epilepsy	
		腎疾患 Kidney disease			心疾患 Heart disease	
		糖尿病 Diabetes			薬剤アレルギー Drug allergy	
	✓	無し None			四肢機能障害 Functional disorder in the extremities	

5. 検査 Laboratory tests							
(1)尿検査 Urinalysis:	糖 glucose		蛋白 protein		潜血 occult blood		
(2)貧血検査 Anemia test	赤沈 ESR	mm/Hr	白血球数 WBC count	/cmm	血色素量 Hemoglobin	gm/dl	貧血 Anemia
(3)肝機能検査 LFT	GPT (ALT)	(IU/l)	GOT (AST)	(IU/l)	γ-GTP	(IU/l)	

6. 医師の診断・意見 Physician's impression of the applicant's health
継続的治療・投薬の必要性があればその旨ご記入下さい。 Please fill in if the applicant needs regular medication or treatment.

7. In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan? 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は十分に留学に耐えうるものと思われますか? <input type="checkbox"/> YES (はい) <input type="checkbox"/> NO (いいえ)	日付 Date
	医師署名 Physician's Signature
	検査施設名 Office/Institution
	所在地 Address

※Please be sure to check either "YES" or "NO". If you do not check "YES", the Embassy will NOT accept the application.
必ず「はい」又は「いいえ」にチェックしてください。「はい」にチェックがない場合、大使館は申請を受理しません。

健康診断書 (2021年度版)

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2. 胸部聴診及びX線検査 (6ヶ月以内) Physical and X-ray examinations of the chest (within six months)

	胸部X線所見 Describe the condition of lungs.	撮影年月日 Date of X-ray	年 月 日 yyyy mm dd
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3. 現在治療中の病気 Disease currently being treated

無 No 有 Yes : 病名 Disease

4. 既往症 Past illness/disorder

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	腎疾患 Kidney disease		心疾患 Heart disease	
	糖尿病 Diabetes		薬剤アレルギー Drug allergy	
<input checked="" type="checkbox"/> 無し None	精神疾患 Psychosis		四肢機能障害 Functional disorder in the extremities	

5. 検査 Laboratory tests

(1)尿検査 Urinalysis:	糖 glucose	蛋白 protein	潜血 occult blood
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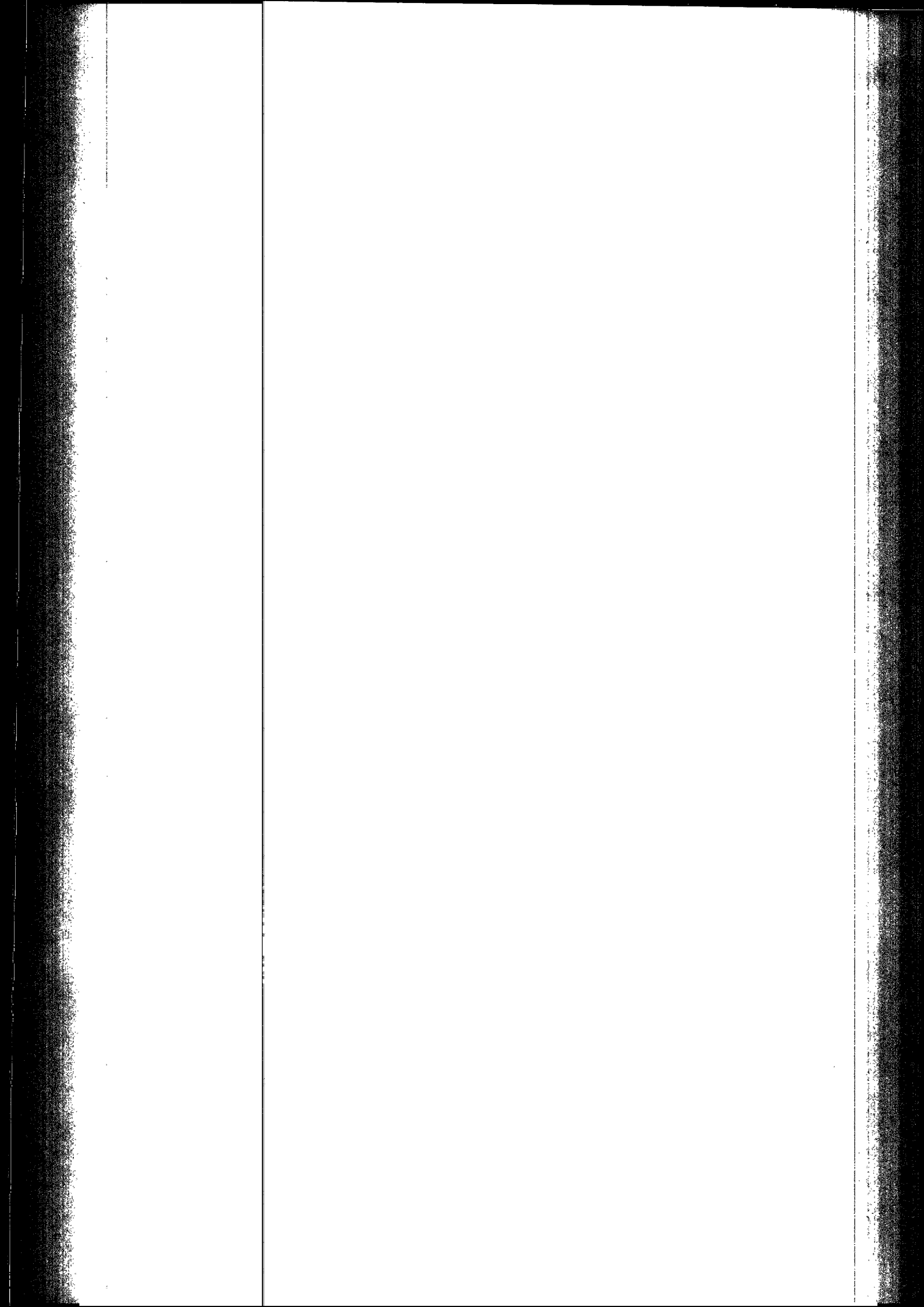
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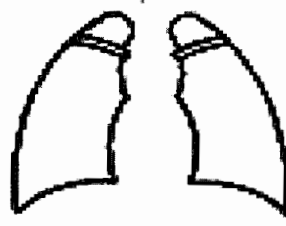
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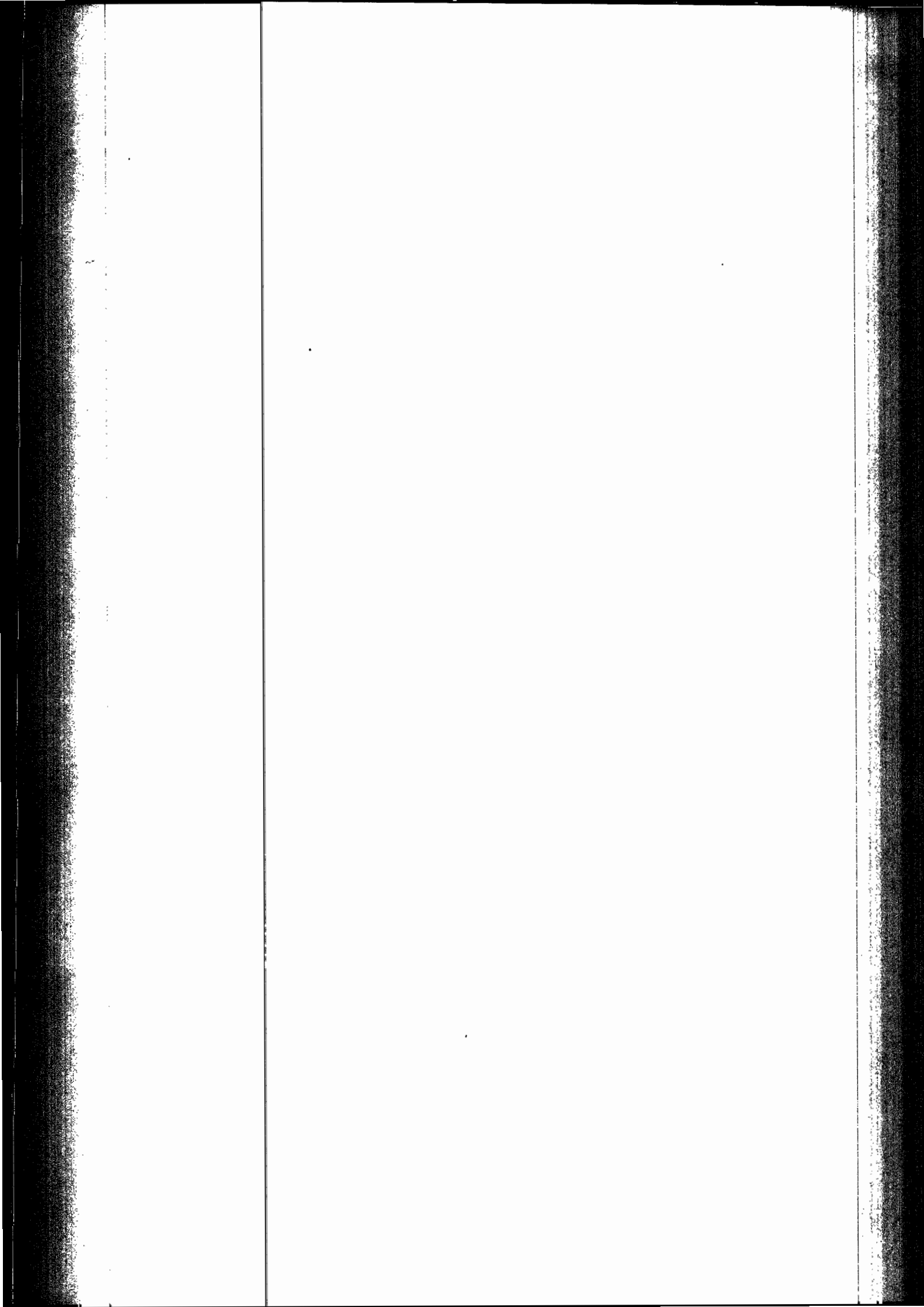
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(2)貧血検査 Anemia test	赤沈 ESR	白血球数 WBC count	血色素量 Hemoglobin
(3)肝機能検査 LFT	GPT (ALT)	GOT (AST)	貧血 Anemia

6. 医師の診断・意見 Physician's impression of the applicant's health

継続的治療・投薬の必要性があればその旨ご記入下さい。
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<input type="checkbox"/> YES (はい) <input type="checkbox"/> NO (いいえ)	日付 Date
	医師署名 Physician's Signature
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健康診断書 (2021年度版)


(医師に記入してもらうこと)
日本語又は英語により明瞭に記載すること。

CERTIFICATE OF HEALTH (for 2021)

(to be completed by the examining physician)
Please fill out (PRINT/TYPE) in Japanese or English.

氏名 Name	Surname 姓	Given name 名	Middle name ミドルネーム
性別 Gender	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	生年月日 Date of Birth	年 月 日 yyyy mm dd

1. 身体検査 Physical examination			
(1)身長 Height	cm	(2)体重 Weight	kg
(3)血圧 Blood pressure	mmHg~	(4)血液型 Blood type	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> RH+ <input type="checkbox"/> RH-
(5)脈拍 Pulse	<input type="checkbox"/> 整 Regular <input type="checkbox"/> 不整 Irregular	(7)色覚異常の有無 Color blindness	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
(6)視力 Eyesight	裸眼 (右) (左) Without glasses (R) (L)	(8)聴力 Hearing	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
	矯正 (右) (左) With glasses or contact lenses (R) (L)	(9)言語 Speech	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired

2. 胸部聴診及びX線検査 (6ヶ月以内) Physical and X-ray examinations of the chest (within six months)			
	胸部X線所見 Describe the condition of lungs.	撮影年月日 Date of X-ray	年 月 日 yyyy mm dd
		フィルム番号 Film No.	
		(1)肺 Lungs	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		(2)心臓 Cardiomegaly	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		異常がある場合⇒心電図 If impaired⇒Electrocardiograph	<input type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired

3. 現在治療中の病気 Disease currently being treated	<input type="checkbox"/> 無 No <input type="checkbox"/> 有 Yes : 病名 Disease
---	---

4. 既往症 Past illness/disorder	✓	病名 Name	完治時期/治療中 Date of recovery /under treatment	✓	病名 Name	完治時期/治療中 Date of recovery /under treatment
該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。 Please check and fill in the date of recovery/under treatment. If NOT contracted any of them in the past, please check "None".		結核 Tuberculosis			マラリア Malaria	
		その他感染症 Other communicable disease			てんかん Epilepsy	
		腎疾患 Kidney disease			心疾患 Heart disease	
		糖尿病 Diabetes			薬剤アレルギー Drug allergy	
✓	無し None	精神疾患 Psychosis			四肢機能障害 Functional disorder in the extremities	

5. 検査 Laboratory tests							
(1)尿検査 Urinalysis:	糖 glucose	蛋白 protein	潜血 occult blood				
(2)貧血検査 Anemia test	赤沈 ESR	mm/Hr	白血球数 WBC count	/cmm	血色素量 Hemoglobin	gm/dl	貧血 Anemia
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6. 医師の診断・意見 Physician's impression of the applicant's health 継続的治療・投薬の必要性があればその旨ご記入下さい。 Please fill in if the applicant needs regular medication or treatment.
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7. In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan? 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は十分に留学に耐えうるものと思われますか? <input type="checkbox"/> YES (はい) <input type="checkbox"/> NO (いいえ)	日付 Date
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	糖尿病 Diabetes		薬剤アレルギー Drug allergy	
	精神疾患 Psychosis		四肢機能障害 Functional disorder in the extremities	
<input checked="" type="checkbox"/> 無し None				

5. 検査 Laboratory tests

(1)尿検査 Urinalysis:	糖 glucose	蛋白 protein	潜血 occult blood
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日付 Date	
医師署名 Physician's Signature	
検査施設名 Office/Institution	
所在地 Address	

Recommendation Form

To the Applicant

Please complete only the top portion of this form. Your recommender should complete the rest of the form.

Your Name (Family)	(Given)	(Middle)

To the Recommender

The person whose name appears above is applying for admission to the Young Leaders' Program.

Please provide your recommendation on your own letterhead or stationery. The Admissions Committee values the recommender's direct contact with the candidate. In your letter, please answer the following questions as candidly and specifically as possible:

Please return this form and your recommendation to the applicant in a sealed envelope, with your signature across the seal. The applicant will submit the sealed, signed envelope to us as part of the completed application package.

The Admissions Committee is aware of the time and care necessary to prepare this form. We gratefully acknowledge your help.

1. How long and in what capacity have you known the applicant?

2. How often have you observed the applicant? (Please tick one box)

every day 3 or 4 times a week 1 or 2 times a week 1 or 2 times a month

less than once a month

9. Please write if you have any comment.

Please provide telephone numbers should the Admissions Committee feel a need to contact you regarding the reference.

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Recommender's Name (please print) _____ Date _____

Position or Title _____ Organization _____

Business Address _____

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