

LAKAS-ANGKAN MINISTRIES, INC.
LEADERSHIP DEVELOPMENT INSTITUTE

April 25 – May 25, 2010
Lakas Angkan National Training Center
 10697 Elon-elon St., Sta. Fe Subdivision
 4031 College, Laguna | Tel. +63 49 5360662



MEDICAL STATEMENT

Last Name	First Name	Middle Name

This form is to be completed by the applicant. Please answer the following questions thoroughly regarding your health. If the answer to a question is yes, please give brief details in the underlined column on the right. You may write on a separate page for more details and explanations.

1. Height: ___ feet ___ inches | Weight: ___ kg
2. Are you now pregnant? If yes, how many months? Yes No _____
3. Would you be able to walk five to ten kilometers per day? Yes No _____
4. Are you taking prescribed or non-prescribed medications?
If yes, what kind? List on the right column. Yes No _____
5. Have you received medical treatment or counseling by a
physician? If yes, list on the right column. Yes No _____
6. Do you have physical or dietary limitations? Specify. Yes No _____
7. Have you suffered in the past or do you now suffer from
problems related to:
 - a. Heart (cardiovascular), lung and/or respiratory system
(tuberculosis, asthma, pneumonia, tumor, etc.)? Yes No _____
 - b. Stomach, ulcers, intestines, liver, kidney (nephritis,
stones, etc.)? Yes No _____
 - c. Nervous system (convulsions, stroke, mental illness,
stress-related disorders, etc.)? Yes No _____
 - d. Glandular system (such as goiter, diabetes, anemia)? Yes No _____
 - e. Blood (anemia, leukemia, other blood disorder)? Yes No _____
 - f. High blood pressure, stroke or circulatory disorder? Yes No _____
 - g. Skin, muscles, bones, joints (arthritis or any muscle
weakness)? Yes No _____
 - h. Sensory organs (eyes, ears, etc.)? Yes No _____
 - i. STD (sexually transmitted diseases), including HIV? Yes No _____

I, the undersigned, have read this Medical Statement and declare that all information given here is true and correct to the best of my knowledge and belief. I waive my right to privacy regarding all medical information and documentation relevant to processing my application for LDI training.

Date (mm/dd/yyyy):	Signature of Applicant
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