THE ALLIED HEALTH PROFESSIONALS COUNCIL
MINISTRY OF HEALTH

Passport Photo

OFFICIAL USE

Status: ……..

Amount: ……..

Signature: ……..

APPLICATION FORM FOR REGISTRATION-AHPC-form 1

1. i) INDIVIDUAL INFORMATION (BLOCK LETTERS)

Surname: ……..First Name: ……

Other names: ……

Gender (tick): Male☐ Female☐ Date of Birth: ……

Nationality: ……Country: ……

District: …… ……Sub county: ……

Marital Status: ……Tribe: ……..

ii) CONTACT ADRESS

i) Personal

Address: …… Residence: ……

Telephone No: ……Alternate Telephone No:……

Email address: ……

ii) Work Place

Place of work:……

Address: ……Telephone No:…… ……

Locality:……District:……

2. EDUCATION INFORMATION

Secondary School attended :(Please attach copies)

O' Level: …… Index Number……

A' level: ……Index Number:……..

4. <u>TRAINING INFORMATION</u>

Training Institution:

……

……

Country of Training: ……

Contact address of Institution: ……

Tel number…… E-mail …….. ……..

Intake date: ……Date of Completion: ……

Reg No …….. Hospital of training: ……

Qualification type: Masters ☐ Degree ☐ Diploma ☐ Certificate ☐

Qualification: ……

Cadre: ……

Have you ever registered before? (If yes, attach details) ……..

Date of registration: …… Signature……..

<u>FOR OFFICIAL USE ONLY</u>

Registration no: …….. Date of verification: ……..

Comments:……

……

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Name……Title:……signature……..