SHIFAH MEDICAL TRAINING COLLEGE

Health through Innovation & research

P.O BOX 37-40308, AMBWERE PLAZA, KITALE, KENYA.
TEL: (0722-378-665)

APPLICATION FORM

Please complete this form in BLOCK LETTERS

PERSONAL DATA

Surname _____ **Middle Name** _____ **First** _____

Date of Birth: ___/___/_____ **Gender: (Tick)** Male [ ] Female [ ]

(Date) (Month) (Year)

Nationality: _____ **Country:** _____ **I.D/Passport No:** _

Marital Status: Single [ ] Married [ ] Other(Specify) _____

Religious Affiliation (Christian, Muslim, Hindu, Specify Other) _____

CONTACT DETAILS

Postal Address: _____ **Postal code:** _____

Town: _____ **County:** _____

Mobile: _____ **Home/Office Tel Number:** _____

Email: _____

PARENT'S/GUARDIANS/NEXTOF KIN'S INFORMATION

Name: _____ **Relationship:** _____

Postal Address: _____ **Postal code:** _____

Town: _____ **County:** _____

Mobile: _____ **Home/Office Tel Number:** _____

Email: _____

FINANCIAL DATA

Who will sponsor your trainings at SMTC? (Tick)

Self [ ] Parent [ ] Guardian [ ] Sponsor [ ]

SELF/PARENT/GUARDIAN/SPONSOR'S INFORMATION

Name: _____Relationship: _____

Postal Address: _____Postal code: _____

Town: _____Country: _____

Mobile: _____Home/Office Tel Number: _____

Email: _____

ATTACH PASSPORT PHOTO ON THIS APPLICATION FORM