THE ALLIED HEALTH PROFESSIONALS COUNCIL
MINISTRY OF HEALTH

OFFICIAL USE

Passport Photo

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:……………………………………………………………

P.T.O

4. TRAINING INFORMATION

Training Institution:

………

………

Country of Training: ……

Contact address of Institution: ……………………………………………………………………………………………

Tel number…………………………………………………… E-mail ……………………………. ……………………………………

Intake date: …………………………………………………Date of Completion: …………………………………………………

Reg No ……………………………………………………………. Hospital of training: ………………………………………………

	Masters	Degree	Diploma	Certificate
Qualification type:	☐	☐	☐	☐

Qualification: ………

Cadre: ………

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

Date of registration: …………………………………………… Signature……………………………………………………

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

Comments:……

………

………

Name………………………………………………………Title:…………………………………signature………………………………

P.T.O