ALLIED HEALTH PROFESSIONALS COUNCIL

APPLICATION FORM FOR OPERATING A PRIVATE ALLIED HEALTH UNIT AHPC form 3

1. Professional's Name: ……
2. Registered Title of the applicant: ……..
3. Registration Number: …….Registration date: ……
4. Name of Health Unit: ……. ……..
5. Postal Address: ……Tel No.……
   Town: ……..…… Plot No ……..……..
6. Locality: ……. Sub county: ……..
   Plot no. …… Street: ……
   City/Town/TC: …… District: ……..
7. Day care centre(Tick)
   - Medical Clinic
   - Dental Clinic
   - Ultra sound Unit
   - Physiotherapy unit
   - Orthopaedic Clinic
   - Ophthalmic/eye clinic
   - Psychiatric Clinic

8. Has any of your applications ever been rejected? Yes/No
   If yes, why……..
   Date: ……Signature: …….....
   Note: Please attach fully filled and stamped checklist from District Health Inspector
   Copy of Registration certificate
   Copy of An Extract from the Register
   Copy of Current Annual Practicing license
   Copy of Diploma Certificate/Transcript

FOR OFFICIAL USE ONLY

Recommendation from Registrar: ……..……..……

……..…..……..……..……

Signature:……..Date:……