|  |  |
| --- | --- |
| Description: amani LOGO | **AMANI COLLEGE OF MANAGEMENT AND TECHNOLOGY(ACMT)**  **P.O. BOX 958, NJOMBE, TANZANIA**  **Tel: 026-2782584, +255 755 549285, E-mail** [***elctsdacmt@gmail.com***](mailto:elctsdacmt@gmail.com)  ***Excellence begins with ethics*** |

**This form consists of Section A to be completed by the applicant and Section B to be completed by a registered medical officer or doctor. The completed form must be submitted along with all the other application materials.**

**SECTION A**

**(TO BE COMPLETED BY THE APPLICANT)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **[*Please Write in Block Letters*]** | |  | **I. PERSONAL INFORMATION** | | |  |  |  |
|  |  | Full Name | First: | Middle: |  | Last: | | Marital Status |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  | Date of Birth |  |  |  | Gender |  | Programme |  |  |

**II. PAST MEDICAL HISTORY**

**(I) NERVOUS SYSTEM**

**Any loss of consciousness?** Yes / No

If yes, dates of incident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Current treatment | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  |  |  | |  |  | |  |  |  |  |  |  |  |  |
|  | **Any neurological deficiency?** Yes / No | | | | | | | | | | | | | |
|  | If yes, state deficiency | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |  |  |  |
|  | When acquired | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
|  | Current treatment | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  | **Any fits?** Yes/No | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | If yes, type of fits | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |
|  | Date of last episode | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  |  |  |  |  |  | |  |  |  |  |  | |  |  |
|  | Current treatment | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |
|  |  |  | |  |  | |  |  |  |  |  | |  |  |
|  | **(II) MUSCULO-SKELETAL SYSTEM** | | | | | | | | | | | | | |
|  |  |  | |  | |  |  |  |  |  |  |  |  |  |
|  | **Any Deformity?** Yes / No | | | | |  |  |  |  |  |  |  |  |  |
|  | If yes, which part of the body | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
|  |  |  |  |  |  |  |  | |  |  | | |  |  |
|  | When acquired | |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |
|  | Use of accessories or aids | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |
|  |  |  | |  | | | | |  |  | | | |  |
|  | **(III) OTHER CHRONIC CONDITIONS** | | | | | | | | | | | | |
|  |  |  | |  | |  |  |  |  |  |  |  |  |  |
|  | **Diabetes Mellitus** Yes / No | | | | |  |  |  |  |  |  |  |  |  |
|  | If yes, when detected | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  | Current Status | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |  |  |  |  |
|  | **Tuberculosis** Yes / No | | | | |  |  |  |  |  |  |  |  |  |
|  | If yes, when detected | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |
|  |  | |  |  | | | | | |  | | | | |
|  | Current status | | Cured / Ongoing treatment | | | | | | | | | | | |

**Herpes Zoster** Yes / No

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If yes, date of illness | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Part of body affected | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |  |
| **Hypertension** Yes / No | | | | | | | | | | | |
| If yes, when detected |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
| Current treatment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Asthma** Yes / No |  |  |  |  |  |  |  |  |  |  |  |
| If yes, when detected | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |
|  |  | | | |  |  |  |  |  |  |  |
| Current treatment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |  |  |  |  |
| **Allergies** Yes / No |  |  |  |  |  |  |  |  |  |  |  |
| If yes, date of last reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
|  |  | | | | |  |  |  |  |  |  |
| Cause of reaction |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |
| **Major Surgeries** Yes / No | | | | | | | | | | | |
| If yes, type of surgery |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  |  |
| Date of surgery |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |
| Outcome of surgery | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |
|  | | | | | |  |  |  | | | |
| **Any Heart Disease** Yes / No | | | | | | | | | | | |
| If yes, what disease? |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
|  |  | | | | |  |  |  |  |  |  |
| Current Treatment |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
|  | | | | | |  |  | | | | |
| **Any Dietary Restrictions** Yes / No | | | | | | | | | | | |
| If yes, state restriction |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Note: The applicant is responsible for maintaining any dietary restrictions.**

**III. DECLARATION**

I declare that all the information provided herein is true to the best of my knowledge.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION B**

**(TO BE COMPLETED BY A REGISTERED MEDICAL OFFICER OR DOCTOR)**

**IV. VARIOUS TESTS**

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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | **(I) GENERAL APPEARANCE** | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **(II) CARDIO-RESPIRATORY SYSTEM** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **(C** |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | **NEEDED)** | | | | | | | | | | |
|  |  | Height | |  | | | | \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |  | Weight | | |  | | | | \_\_\_\_\_\_\_\_\_\_ | | | |  |  | **HEST X-RAY FILM & REPORT ARE** | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  | Lung Fields \_\_\_\_\_\_\_\_\_\_\_ Breast Lumps \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Blood Pressure \_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | Pulse Rate \_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Heart Size | | |  |  | \_\_\_\_\_\_\_\_\_\_\_ Heart Sounds \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Lymphnode Palpable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **(III) ABDOMINAL EXAMINATION** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Skin Appearance | | | | | | | | |  | | | | \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | **(ABDOMINAL U.S.S. REPORT IS NEEDED. IF MASS DETECTED** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Throat Tonsils | | | | | | | | |  | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |  |  |  |
|  |  |  |  |  | **FILM IS NEEDED)** | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Teeth Dentition \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  | Carious | | \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |  |  | Contour: Sunken / Normal / Distended | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | EARS: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Skin Scar | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |
|  |  | Rt Hearing \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Drum Membrane \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  | Umbilicus \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  | | |  | |  |  |  |  | | | | | |  | |  | |  | |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Lt Hearing \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Drum Membrane \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  | **(IV) MUSCULO SKELETAL SYSTEM** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | EYES: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | | | |  |  |  |  |  |  | |  |  |  | |  | |  |  | | |  |  |  |  |
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|  |  | Rt VA | | \_\_\_\_\_\_\_\_\_\_ | | | | | |  |  |  |  |  | Squint | | | | |  | \_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  |  |  | If yes which part of the body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  | |  |  | | |  |  |  |  |  |  | | | | |  |  | |  | | | | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Lt VA | | \_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |  |  |  | Squint | | | | | \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |  |  |  |  | Type of deformity | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **V. LABORATORY** | | | | | | | | | | | | **INVESTIGATIONS** | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **(I) BIOCHEMICAL** | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **(III) HEMATOLOGY** | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | |  |  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | **)** |  | | | | | | | | | | | | | | | | | | | |
|  |  | Fasting Blood Sugar | | | | | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  |  |  | **(CULTA COUNTER** | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Haemoglobin | | | | | | | \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ | | | | | | | | | | | | |  |  |  |  |  |  |  |
|  |  | Serum Creatinine | | | | | | | | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |
|  |  |  |  | White Cells Count | | | | | | |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  |  |  |  |  |  |  |  |
|  |  | Serum Aspantate T. | | | | | | | | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | **(IV) PARASITOLOGY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Serum Alanine T. | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |  |  |  |
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|  |  |  |  |  | Stool Routine Examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Blood Urea | | | | | | | | |  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Uric Acid | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |  |  |
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|  |  |  |  | Urinalysis & Sediment Microscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | **(II) IMMUNOLOGY** | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Treatment \_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |  |  |
|  |  |  |  | | | |  | | | | | | | | | | | | | |  | |  | | | | |  | | |  |  |  |  | |
|  |  | VDRL Reaction if +ve treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  | |
|  |  |  |  |  | | | | | | | | | | | | | |
|  |  |  | | | | | | | | | | | | | | | | |  |  |  | |  | | | | |  | | |  |  |  | Blood Smear for Protozoa, Hemoflagellets & Spirachaetae | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Widal Reaction if +ve treatment | | | | | | | | | | | | | | | | |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |  |  |
|  |  | Contact with Human Immunodeficiency Virus Sero | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
|  |  | Conversion (Optional) | | | | | | | | | | | | |  |  |  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |  |  | Treatment | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **VI. OTHER** | | | | | | **OBSERVATIONS** | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Any other observations whether irritable or aggressive: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **VII. DECLARATION** | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | I Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | . | |  |  |  |  |  |  |  |  |  |  |  | has examined the named candidate | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | and conclude that the candidate is / is not suitable to attend a three year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Diploma programme at Amani college of Management and Technology | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Signature with Official Stamp | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |  |  |  |  |  | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |