|  |  |
| --- | --- |
| 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******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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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **(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: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Any Deformation? Yes / No |
|  |  | Rt VA | \_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  | Squint |  | \_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  | If yes which part of the body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Lt VA | \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Squint | \_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  | Type of deformity | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **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. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Stool Routine Examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Blood Urea |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Uric Acid | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Urinalysis & Sediment Microscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | **(II) IMMUNOLOGY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 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 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **VI. OTHER** | **OBSERVATIONS** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Any other observations whether irritable or aggressive: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |