ST.AMBROSE INSTITUTE OF HEALTH SCIENCES
P.O BOX 164, Kagadi –UGANDA
Tel: 0783054123

Attach your most recent passport size photo

APPLICATION FORM FOR DIPLOMA IN NURSING AND MIDWIFERY EXTENSION PROGRAMMES.

Date: …….

PERSONAL INFORMATION

Sur name: …….Other Name: ……

Village: …….Parish: …….

Sub-county: ……..District: ……...

Sex (tick one) ☐ Male ☐ Female

Applicant's Telephone number: ……

Email address.....

Nationality: …….....NIN for applicant.....

Date of birth: ……..Age: ……..

Next of kin..... Telephone number for next of kin.....

NIN for next of kin.....

Marital status (tick one) ☐ Single ☐ Married

Name of spouse ……..Number of dependents ……

Parent/ Guardian

Name: ……

Occupation: ……Tel: ……

A. ACADEMIC INFORMATION

NOTE**: You <u>MUST</u> attach photocopies of certified academic documents awarded at subsequent levels of training.**

Course desired (tick one)

Diploma in Nursing extension ☐ Diploma in Midwifery extension ☐

Please list activities or sports you would be capable of and willing to engage in.

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B. Uganda Nurses and Midwives Examinations Board (UNMEB)

Programme offered.....

Year and month of entry into the programme.....

Year and month of completion of the programme.....

Award.....

Nursing/Midwifery institution.....

Reg Number/NSIN.....

UNMEB certificate Number.....

UNMEB transcript serial Number.....

C. Uganda Nurses and Midwives Council (UNMC)

(a) Practicing License.

Year of enrolment at UNMC.....

Current practicing license number.....

Serial number of the current practicing license.....

Date of issue of current practicing license.....

Date of expiry of the current practicing license.....

(b) Certificate of Registration at UNMC.

Certificate of registration number.....

Date of issue of certificate of registration.....

D. Uganda Certificate of Education (UCE)

Year of Examination ……Index No ……..
Name of School …….City/Town ……..
Dates attended (from –to) ……..

Subject	English	Mathematics	Chemistry	Biology	Physics
Grade					

Division: …… Aggregates: ……

E. Primary Leaving Examination (P.L.E)

Division: ……..Aggregates: ……..

F. EMPLOYMENT HISTORY/WORKING EXPERIENCE.

S.N	NAME OF FACILITY	DESIGNATION	FROM	TO

Total years of working experience.....

G.SPONSORSHIP

If self-sponsored write "self" ……..

If you are being sponsored by someone write his/her details below:

Name of Sponsor …….Address: ……

Tel: …….Email: ……

H.MEDICAL HISTORY

Do you have any chronic disease, disability or health complication?

Yes ☐ No ☐

If yes, describe the nature of your health issue.

……

Attach copies of the medical forms to back up your description.

How did you get to know about this Institute?

☐ Student, Name of student. ……

☐ Radio Adverts, Name of the Radio station.…….

☐ Others, Specify..……

NOTE: **Please, carefully note the following:**

1. The application fee is Shs.**20, 000** and must be paid on the institute bank accounts.

2. Applicants **MUST** submit completed application forms to the Academic Registrar (St. Ambrose Institute of Health Sciences).

3. This application form does not guarantee an admission to the Institute, you will only be considered after passing the entry interviews at a cost of Shs.**30,000/=**

4.For more information contact our office line on 0783054123.

5**. All payments must be paid on our bank accounts listed below:**

Account Name	**Account Numbers**
St.Ambrose Institute of Health Sciences	**Stanbic:9030018176903**
	Centenary: 3100074947

FOR OFFICIAL USE ONLY:

☐ Admitted. ☐ Not Admitted

COURSE ADMITTED FOR …… ……..

Date received: …….Received by…….