TANZANIA TRAINING CENTRE
FOR
ORTHOPAEDIC TECHNOLOGY

P.O.Box 8690 – MOSHI,TANZANIA

TEL: 0255-27-27-53986/7

FAX: 0255-27-27-52038

E-mail:tatcot@kilinet.co.tz
Or: mtalo@kilinet.co.tz

APPLICATION FOR ADMISSION TO VARIOUS COURSES IN ORTHOPAEDIC TECHNOLOGY

I: PERSONAL DETAILS:

Surname or Family Name : …………………………………………..

Other Names : …………………………………………..

Title: Dr/Mr/Mrs/Miss

Date of Birth ….. ….. ……
(D) (M) (Y)

Marital : Maried ( )

Status : Single ( )

Nationality :

Address for Correspondence

Post Box :………………………………………………………………………….

Telephone:………………………………………………………………………

Fax :………………………………………………………………………………….

E-Mail :…………………………………………………………………………….

Official Language of Communication

	Good	Average	Elementary
English	[ ]	[ ]	[ ]

II: ACADEMIC QUALIFICATIONS

NB: Please attach transcripts and/or documentary evidence of all Pre and Post School qualifications

Name of the School/College	: Date attended:	Main subjects:	: Award obtained
1.	: :	1…………..	:
	: :	2…………..	:
	: :	3…………..	:
	: :	4…………..	:
2.	: :	1…………..	:
	: :	2…………..	:
	: :	3…………..	:
	: :	4…………..	:
3.	: :	1…………..	:
	: :	2…………..	:
	: :	3…………..	:
	: :	4…………..	:
4.	: :	1…………..	:
	: :	2…………..	:
	: :	3…………..	:
	: :	4…………..	:

III: STATE THE COURSE OF STUDY INTENDED
Tick the corresponding course of study applied

S/N	Course of study	Duration	Tick
1	Diploma in Orthopaedic Technology	3 Years	
2	Certificate in Lower Limb Prosthetics	One Year	
3	Certificate in Lower Limb Orthotics	One Year	
4	Certificate Course in Wheelchair Technology	One Year	
5	E-Learning in Spinal Orthotic	One Year	

IV: PROFESSIONAL AND OTHER QUALIFICATIONS:

Name of awarding Institution/Body	:Subject (s) in which : Award was obtained :	:Qualification obtained :give dates whether obtained :by Examination/exemption
………………………………	:……………………..:	……………………………
………………………………..	:……………………	: …………………………..
………………………………..	:…………………….	: …………………………..

V EMPLOYMENT AND EXPERIENCE:

Give details of your present employment (if any) and any previous employment, including name and address of employer (s), position held, type of work undertaken and dates.
……………………………………………………………………………………………..

VI: SOURCE OF FINANCE

Please state how you intend to finance your proposed study. Give details of any application(s) for Scholarship that you have made. If a Scholarship has been awarded, please attach a copy of the award letter.

VII: DECLARATION

I certify that the answers and other information given in this application are correct and complete. If I am admitted to TATCOT I undertake to observe the School regulations and ensure discipline and Cooperation.

Signature of Applicant…………………………….Date…………………….

The Completed application form should be sent to the below address.

The Principal
TATCOT
P.O.Box 8690
Moshi – Tanzania

Fax:0255-27-2752038
E-mail:tatcot@kilinet.co.tz

TANZANIA TRAINING CENTRE
FOR
ORTHOPAEDIC TECHNOLOGISTS

MEDICAL EXAMINATION REPORT

(To be attached to the application form for admission)

CONFIDENTIAL
…………………………………………………………

I: PERSONAL DATA:

Name of Applicant (Surname): …………………………………………………………..
Other Names : …………………………………………………………..
Date of Birth : …………………………Place of Birth…………………
Passport Number : …………………………Address……………………….
Marital status : Single/married…………Number of children……………
Trained as : …………………………Last employed as……………..

II: DETAILS OF MEDICAL HISTORY

A: Family Anamnesis (Incl.Mental diseases,TB,Cancer,epilepsy-parents,brothers sisters and Children)

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B: APPLICANT'S ANAMNESIS

Past, Present or chronic disorders

a: Disease of the heart, circulation, digestion and respiratory organs, reno-urinary passages. inner-secretory glands (diabetes),bone and locomotor system, sensory organs and skin, rheumatic and or allergic diseases, nervous and mental disorders

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b: Tubercular Diseases (T.B. of lungs,bones,joints,glands or other organs)

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c: Further infectious diseases (diaptheria,spotted fever,epid.hepatitis,veneral diseases,meningitis,poliomyelitis,malaria,dysentery,typhoid,trachoma,yellow fever etc.)

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III: CONGENITAL DISEASES

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IV: Impaired health due to accidents (if possible give details especially with regard to the kind, time and persisting symptoms of damage suffered)

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V: OPERATIONS IF ANY
(If possible, give kind and date)

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VI: PHYSICAL DISABILITY IF ANY
(If possible, give kind)

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VII: HIV-1 AND HIV-2 SCREENING TEST

		Results	
0	HIV-1 Enzyme immuno Assay (supplier/Date………/…….	0 pos.	0 neg.
0	HIV-2 Enzyme Immuno Assay (Supplier/Date……/……….	0 pos.	0 neg.
0	HIV-1/HIV-2 Comb-Test (Supplier/Date…../………..	0 pos.	0 neg.

For the Medical point of view and after due consideration of the conditions prevailing, I herewith declare the Applicant **Suitable/Unsuitable** to pursue the Training.

Signature of the Examining Physician………………………..Date……………………….