



BUGANDO MEDICAL CENTRE
SCHOOL OF ANESTHESIA
APPLICATION FOR ONE YEAR CERTIFICATE COURSE IN NURSE ANESTHESIA-
ACADEMIC YEAR JANUARY TO DECEMBER 2020.

You are welcome to apply to study Anesthesia at our Bugando school of Anesthesia . Please fill in the spaces provided and submit your application to Bugando school of Anesthesia using either of the options below. The application is open from 21ST October 2019 and the deadline for application is December 30TH , 2019.

PART ONE: DETAILS OF APPLICATION

APPLICATION PROCESS:

Can be done through any of the following:

- Application form delivered personally or
- Delivered by post mail: address

PRINCIPAL,
BUGANDO SCHOOL OF ANESTHESIA
P.O BOX 1370,
MWANZA.

- By email: drkenemo@gmail.com

When applying please indicate your correct email address and current phone number.

REQUIREMENTS/CRITERIA TO JOIN:

- (a) Applicant must be a nurse or clinical officer. We do not receive fresh from secondary school or professions other than the two mentioned.
- (b) Must attach all verified copies of secondary education and professional training-nursing or clinical medicine.
- (c) A Medical Certificate stating that you are fit to follow this course (Form attached)
- (d) Two (2) passport-size photos of yourself.
- (e) Photocopies of your relevant certificates including Internship certificate and registration certificate with Medical Council of Tanganyika.
- (f) A recommendation letter from your employer is an added advantage.

APPLICATION FEE:

After abiding to above regulations, attach original copy of non refundable application fee of Tsh. 20,000/= paid through the following bank account:

BMC VYUO COST SHARING

A/C NUMBER 01J1054747600 CRDB BUGANDO BRANCH.

Applicants who do not pay application fee will not be considered for selection!

PART TWO: OTHER DETAILS:

1. FEES, RESIDENCE AND OTHER EXPENSES

FEE STRUCTURE ONE YEAR TRAINING IN ANESTHESIA JANUARY TO DECEMBER 2020.

S#	PAYMENT/ITEM	PAYABLE TO	AMOUNT
1	CASE LOG BOOK	TO THE COLLEGE	20,000/=
2	TUITION FEE	TO THE COLLEGE	850,000/=
3	CAUTION MONEY	TO THE COLLEGE	20,000/=
4	EXAMINATION FEE	TO THE COLLEGE	100,000/=
5	CASE REPORT	TO THE COLLEGE	100,000/=
6	FIELD SUPERVISION	TO THE COLLEGE	50,000/=
7	CERTIFICATE	TO THE COLLEGE	15,000/=
8	STUDENT UNION & SPORTS	TO THE COLLEGE	10,000/=
9	STIPEND	STUDENT	3,600,000/=
10	ACCOMMODATION	STUDENT	480,000/=
11	BOOKS ALLOWANCE	STUDENT	200,000/=
12	FIELD ALLOWANCE	STUDENT	150,000/=
13	MEDICAL INSURANCE	STUDENT	50,400/=
TOTAL			5,645,000/=
1	TOTAL AMOUNT PAYED DIRECTLY TO THE STUDENT		4,480,400/=
2	TOTAL AMOUNT PAYED DIRECTLY TO THE COLLEGE		1,165,000/=
TOTAL COST OF FOR ONE STUDENT PER YEAR			5,645,400/=

Money directly payable to the college should be paid through:

BMC VYUO COST SHARING
A/C NUMBER 01J1054747600 CRDB BUGANDO BRANCH.

2. PERSONAL DETAILS:

Your name: [SURNAME] _____ [FIRST NAME] _____ [MIDDLE NAME] _____

Male/Female [M/F] ADDRESS _____ CITY _____ TELEPHONE _____

Email: _____

Date of birth: [DD/MM/YY] ____/____/____ Place of birth _____ Nationality _____ Passport #: _____

For Emergencies:

NAME: _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ PHONE: _____ EMAIL: _____

3. ACADEMIC DATA

ALL SEC.SCHOOOLS ATTENDED	LOCATION	DATE: FROM (MO/YR)	TO (MONTH AND YEAR)	CERTIF.INDEX NO
ALL COLLEGES/SCHOOLS	LOCATION	DATES: FROM	TO	DIPL/CERT.EARNED

Total number of years of schooling: _____ years and _____ months [From secondary school].

4. LANGUAGE FLUENCY [Please put a tick for each language]

LANGUAGE	SPOKEN			WRITTEN		
	FAIR	GOOD	VERY GOOD	FAIR	GOOD	VERY GOOD

5. Names and addresses (email and phone numbers) of two referees who know your ability as a student and can assess your competence in written and spoken English.

a) _____ Email: _____ Phone: _____

b) _____ Email: _____ Phone: _____

6. SIGNATURE AND DATE

I certify that to the best of my knowledge the information I have given above is correct.

(Date) (Signed)

7. SPONSORSHIP.

The Sponsor should indicate here that the candidate will receive financial support for the years he or she will spend at Bugando University College.

NAME OF SPONSOR _____

P.O. BOX CITY OR TOWN _____ TEL/MOB: _____

BUSINESS OR ACTIVITY _____ FAX/E-MAIL _____

I myself,

I confirm that my organization will give full financial support to _____ during the period of his/her education at Bugando school of Anesthesia, if he/she is accepted.

(date) _____ (Signed) _____

Official stamp or seal

FOR OFFICIAL USE ONLY

PLEASE ENCLOSE PHOTOCOPIES OF ALL TRANSCRIPTS

YOU ARE MOST WELCOME.

By: HEAD BUGANDO SCHOOL OF ANESTHESIA



MEDICAL CERTIFICATE

SURNAME..... OTHER NAMES..... AGE.....SEX

MARITAL STATUSCITIZENSHIP.....

PERSONAL HISTORY

Is the examinee suffering from any of the following? Indicate Yes or No.

Dysentery _____ Kidney or urinary disease _____
Epilepsy _____ Psychosis _____
Pneumonia _____ Sickle cell disease _____
Allergic disorder _____ (mention allergen) _____
Gastric or duodenal Ulcer _____ Jaundice _____
Varicose Veins _____ Diabetes _____
Body Deformity _____ Eye disorder _____
Skin disease _____ Gynecological disorder _____
Major trauma _____ Tuberculosis _____
Pleurisy _____ Rheumatic Fever _____
Heart Disease _____ Recurrent indigestion _____
Ear , Nose or Throat disorder _____ Chronic Anemia _____
Malaria _____ Major or minor operations _____
Any other serious disorder _____ History of TB contact _____
Immunization history: _____

PHYSICAL EXAMINATION

Height: _____ cm Weight: _____ kg. HEENT: _____
Ears(Any discharge): _____ Nose: _____
Cardiovascular: BP _____ mmHg HR _____ Regular Any murmurs: _____
Respiratory: Wheezing: _____ Breath sounds: _____ RR _____
Abdomen: _____ Hernia: _____ Masses _____ Liver _____ Kidn
eys _____ Spleen _____

LABORATORY RESULTS

Urinalysis: Sugar _____ Bilharzia _____ Albumin _____

Stool: Worms _____

Blood: FBP-Hb _____ g/dL Blood group _____

Neutrophils _____ Eusinophils _____ Bisophils _____ Lymphocytes _____

Monocytes _____ ESR _____ Platelets _____

Chest Xray:(If Indicated) _____ ECG _____

ECHO _____

CONCLUSION

I have examined Mr/Mrs/Miss/Sr/Br/Fr/Dr _____ and considered that she/he is /
not physically and mentally fit to be admitted for further studies.

Name

Signature

Date

Title

Qualifications

Address/Institution

Official stamp [of hospital]