You are welcome to apply to study Anesthesia at 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 1st of December 2020 and the deadline for application is January 31st 2021.

**PART ONE: DETAILS OF APPLICATION**

**APPLICATION PROCESS:**
Can be done through any of the following:

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

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

- By email: bugandoschoolofanesthesia@gmail.com

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

**REQUIREMENTS:**
(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 undertake this course.
(d) Two (2) recent 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 qualification

**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 2019-2020.

<table>
<thead>
<tr>
<th>S#</th>
<th>PAYMENT/ITEM</th>
<th>PAYABLE TO</th>
<th>AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>CASE LOG BOOK</td>
<td>TO THE COLLEGE</td>
<td>20,000/=</td>
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<tr>
<td>2</td>
<td>TUITION FEE</td>
<td>TO THE COLLEGE</td>
<td>850,000/=</td>
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<td>3</td>
<td>CAUTION MONEY</td>
<td>TO THE COLLEGE</td>
<td>20,000/=</td>
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<td>4</td>
<td>EXAMINATION FEE</td>
<td>TO THE COLLEGE</td>
<td>100,000/=</td>
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<td>5</td>
<td>FIELD SUPERVISION</td>
<td>TO THE COLLEGE</td>
<td>50,000/=</td>
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<tr>
<td>6</td>
<td>CERTIFICATE</td>
<td>TO THE COLLEGE</td>
<td>15,000/=</td>
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<tr>
<td>7</td>
<td>STUDENT UNION &amp; SPORTS</td>
<td>TO THE COLLEGE</td>
<td>10,000/=</td>
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<tr>
<td>8</td>
<td>FIELD &amp; CASE REPORT</td>
<td>STUDENT</td>
<td>100,000/=</td>
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<td>9</td>
<td>STIPEND</td>
<td>STUDENT</td>
<td>3,600,000/</td>
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<td>10</td>
<td>ACCOMMODATION</td>
<td>STUDENT</td>
<td>480,000/=</td>
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<td>11</td>
<td>BOOKS ALLOWANCE</td>
<td>STUDENT</td>
<td>200,000/=</td>
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<td>12</td>
<td>FIELD ALLOWANCE</td>
<td>STUDENT</td>
<td>300,000/=</td>
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<td>13</td>
<td>MEDICAL INSURANCE</td>
<td>STUDENT</td>
<td>50,400/=</td>
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<td>TOTAL</td>
<td></td>
<td>5,645,400/=</td>
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<td>TOTAL AMOUNT PAYED DIRECTLY TO THE STUDENT</td>
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<td>4,730,400/=</td>
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<td>TOTAL AMOUNT PAYED DIRECTLY TO THE COLLEGE</td>
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<td>1,065,000/=</td>
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<td>TOTAL COST OF FOR ONE STUDENT PER YEAR</td>
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<td>5,795,400/=</td>
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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: [FIRST NAME]_____________________[MIDDLE NAME]____________________[SURNAME]____________________

Male/Female [M/F] ADDRESS____________________CITY____________________Mobile phone:____________________

Email:______________________________

Work station:______________________________ (hospital)

Date of birth:[DD/MM/YY]____/____/____ Place of birth________________ Nationality________________ Passport #:____

For Emergencies:
NAME:__________________________________________RELATIONSHIP____________________

ADDRESS__________________________CITY________________PHONE:________________________EMAIL:________________________
3. ACADEMIC DATA

<table>
<thead>
<tr>
<th>ALL SEC SCHOOLS ATTENDED</th>
<th>LOCATION</th>
<th>DATE: FROM (MO/YR) TO (MONTH AND YEAR)</th>
<th>CERTIF. INDEX NO</th>
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<tr>
<td>ALL COLLEGES/SCHOOLS</td>
<td>LOCATION</td>
<td>DATES: FROM TO</td>
<td>DIPL/CERT. EARNED</td>
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Total number of years of schooling: ___________ years and ___________ months [From secondary school].

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

<table>
<thead>
<tr>
<th>LANGUAGE</th>
<th>SPOKEN</th>
<th>WRITTEN</th>
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<tbody>
<tr>
<td></td>
<td>FAIR</td>
<td>GOOD</td>
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<td>FAIR</td>
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</tbody>
</table>

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 STATUS …………………………….CITIZENSHIP………………………………

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______________
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 ________________

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 ___________Kidneys________________ Spleen________________
LABORATORY RESULTS

Urinalysis: Sugar _________ Bilharzia _________ Albumin___________

Stool: Worms_____________

Blood: FBP-Hb ________ g/dL

Neutrophils___________ Eusinophils___________ Bisophils___________ Lymphocytes___________

Monocytes_____________ ESR_____________ Platelets_______________

Chest Xray:(If Indicates)____________________ 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]