MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

INSTITUTE OF TRADITIONAL MEDICINE

FOR OFFICIAL USE ONLY

PASSPORT SIZE PHOTO HERE

APPLICATION FORM FOR THE SHORT COURSE TRAINING ON TRADITIONAL MEDICINE DEVELOPMENT IN SEPTEMBER 2017

Please read carefully the instructions before filling this form. Deadline for application and payment is **31/08/2017**. The course will take place from **11th to 15th September, 2017**.

1.1 **Full Name**: ……
1.2 **Sex**: Male [ ] Female [ ]
1.3 **Date of birth**: …….
1.4 **Place of birth**:
DISTRICT……. REGION……..COUNTRY…….
1.5 **Place of residence**: WARD: ……DISTRICT: ……
REGION: …….. COUNTRY…….
1.6 **Tribe**: ……..
1.7 **Religion**: ……..
1.8 **Marital status**: Tick appropriate option. Married [ ] Note married [ ]
1.9 **Postal Address**: ……
……
1.10 **Phone Number (s):** ……

2.0 LEVEL OF EDUCATION (Tick appropriate option)

S/N	**Level**	
1.	Primary Education	
2.	Secondary Education	
3.	Certificate	
4.	Diploma	
5.	Degree	

3.0 OCCUPATION: Tick Appropriate option

a. Traditional Health Practitioner/Healer only

b. Traditional Health Practitioner/Healer and other work

c. Other work

4.0 PAYMENT OF COURSE FEE:

a. Paid [ ]. If paid attach a copy of bank slip

b. Not paid [ ]

c. Who paid for your course fees: a. Yourself [ ] b. Relative [ ] c. Sponsor [ ]

5.0 DECLARATION

I DECLARE THAT THE INFORMATION GIVEN IN THIS FORM IS CORRECT.

APPLICANT SIGNATURE: ……..DATE: ……

HOW TO PAY

The cost for this course is **Tshs 350,000 for Tanzanian citizens** and **USD 300** for **non-Tanzanian citizens**. The cost covers tuition fees, breakfast and lunch. Transport, dinner and accommodation costs will be covered by the applicant. The fee should be deposited at **NMB Muhimbili Branch, Account Number 2091100002** not later than **31st August, 2017**. Foreign currency can be deposited using Swift Code system. Muhimbili University of Health and Allied Sciences, NBC Samora Branch, Bank Account Number 012105003582, SWIFT NO. SAMORA BRANCH NLCBTZTXXXXX

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THIS APPLICATION FORM HAS BEEN RECEIVED AT THE INSTITUTE OF TRADITIONAL MEDICINE.

NAME OF RECIVING OFFICER: ……SIGNATURE: …….DATE: ...….

DECISION BY THE INSTITUTE: ……..