KILIMANJARO CHRISTIAN MEDICAL UNIVERSITY COLLEGE
(A Constituent College of Tumaini University Makumira)

APPLICATION FORM FOR ADMISSION TO PHD PROGRAMMES - ACADEMIC YEAR 2020/2021

GENERAL INSTRUCTIONS:
This form contains important information. Please read the form carefully and make sure that you have covered everything on the form before submission. Return an appropriately filled form to the Admissions officer at the KCMU-College with the necessary attachments. Please provide a reliable e-mail address for correspondence. Deadline for receiving PhD applications are 31st May, 2020.

Application fee: Application fee is 100,000 Tanzanian shillings (100 US dollars for foreign applicants). You should pay the fee through the college bank account as shown below. A copy of the pay-in slip should be attached with the filled forms. The original copy will be required for verification when the applicant reports for registration at the college and the college bursar will issue a receipt to confirm the payment.

The forms will not be processed if proof of payment of application fee is lacking.

The Account is as follows:
Kilimanjaro Christian Medical College
Local Account (Tshs): 017101001339
NBC Moshi Branch
TANZANIA
Forex Account (Dollar account): 017105000676
SWIFT CODE, NLCBTZTX
NBC Moshi Branch
P. O. Box 3030, MOSHI – TANZANIA
PHD PROGRAMMES ACADEMIC YEAR 2020/2021

(PLEASE TICK ON THE PROGRAMME OF YOUR CHOICE)

Doctor of Philosophy (PhD - Clinical Medicine)  ( )
Doctor of Philosophy (PhD in Public Health & Health System)  ( )
Doctor of Philosophy (PhD in Epidemiology)  ( )
Doctor of Philosophy (PhD in Biomedical Sciences)  ( )
Doctor of Philosophy (PhD - Other Specify)  ( )

Attachments: When returning the filled application form (as hard copy), the following papers should be attached:

i) A copy of the bank pay-in slip as evidence for having paid the application fee
ii) A copy of certified Secondary school certificates and transcripts indicating academic Performance
iii) Proof of availability of sufficient funds to pursue the course.
iv) Undergraduate degree certificate and transcript.
v) Master degree certificate and transcript.
vi) For MD/MMed applicants, copy of Internship certificate
vii) For MSc. Midwifery applicants, copy of a valid midwifery license to practice
viii) Curriculum Vitae with names and contacts of three referees
ix) List of publications and awards (if any)
ix) TOEFL iBT score of 65 and above (non-English speaking)
xi) A medical examination form
xii) Preliminary PhD research proposal of at least 15 pages.

Duly filled documents and forms to be sent to:

The Deputy Provost for Academic Affairs (Admissions Officer)
Kilimanjaro Christian Medical College
P. O. Box 2240, MOSHI, Tanzania
Telephone 255-27-2753616
Fax: 255-027-2751351
Email: admission@kcmuco.ac.tz
Web page: http://www.kcmuco.ac.tz
NOTE: Please fill the form using block (capital) letters

1 Doctor of Philosophy (Ph.D) Applicants:

Title of Research Topic:-

A: PERSONAL PARTICULARS:

(i) Surname (Block letters) ____________________________
(ii) First Name in Full (Block letters) __________________
(iii) Middle names in full (Block letters) __________________

Note: The names in which you’ll be registered are those which appear on your form IV Certificate.

(iv) Sex: Male _______ Female _______

(v) Date of Birth: _______ Month _______ Year _______

(vi) Place of Birth: District _______ Region _______

(vii) Marital status _______

(viii) Religion: _______

(ix) Citizenship: _______

(x) Country of Residence: _______ District: _______

(xi) Current Address to which information should be mailed.

Email: ____________________________________________

Phone: __________________ Fax: __________________

Postal Address: ____________________________________________

Medical information*

(xii) Do you have any physical or communication disabilities? (Tick/whichever is applicable):


If any of the above is present give details of disability__________________________

________________________________________________________

________________________________________________________

________________________________________________________
b) Duration of the disability: ________________________________

*N.B: This information is to prepare the University College to receive you and will not mitigate against your admission.

B: (a) ACADEMIC QUALIFICATIONS

<table>
<thead>
<tr>
<th>1st Degree</th>
<th>2nd Degree</th>
<th>3rd Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awarding University/College:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of Award:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPA (if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class: (if applicable)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) Professional Awards:

(a) Award: ________________________________

(b) Awarding Institution/Association: ________________________________

(c) Duration of Programme: ________________________________

(d) Year of Award: ________________________________

C. PROFESSIONAL/WORKING EXPERIENCE:

(i) Current employment and position held: ________________________________

(ii) Current Employer and address: ________________________________

(iii) Previous employment and position held: ________________________________

D. Indicate if Permission has been given by a current employer: ________________

E. FINANCIAL SPONSORSHIP (FOR COLLEGE FEES):

Give full name and addresses: ________________________________
F. YOUR CONTACT INFORMATION:

Address to which information should be sent if your applicant is successful:
(Information will be sent to successful candidates only)

Email: ___________________________ Phone: ___________________________
Postal Address: __________________________
Fax: __________________________________

NOTE: Change of address must be communicated to the Admissions Officer

Statement by Applicant:
I have acquainted myself with the instructions for application to the Kilimanjaro Christian Medical University College and certify that to the best of my knowledge the information given above is correct.

Date: ___________________________ Signature of Applicant: ___________________________
________________________________________________________________________
**MEDICAL EXAMINATION FORM**

This form consists of Section A to be completed by the applicant and Section B to be completed by a registered medical officer or doctor. The completed form must be submitted along with all the other application materials.

### SECTION A

**(TO BE COMPLETED BY THE APPLICANT)**

**[Please Write in Block Letters]**

<table>
<thead>
<tr>
<th>I. PERSONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Name</strong></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
</tr>
</tbody>
</table>

**II. PAST MEDICAL HISTORY**

1. **NERVOUS SYSTEM**
   - **Any loss of consciousness?** Yes / No
   - **If yes, dates of incident**
   - **Current treatment**
   - **Any neurological deficiency?** Yes / No
   - **If yes, state deficiency**
   - **When acquired**
   - **Current treatment**
   - **Any fits?** Yes / No
   - **If yes, type of fits**
   - **Date of last episode**
   - **Current treatment**

2. **MUSCULO-SKELETAL SYSTEM**
   - **Any Deformity?** Yes / No
   - **If yes, which part of the body**
   - **When acquired**
   - **Use of accessories or aids**

3. **OTHER CHRONIC CONDITIONS**
   - **Diabetes Mellitus** Yes / No
   - **If yes, detected**
   - **Current Status**
   - **Tuberculosis** Yes / No
   - **If yes, detected**
   - **Current status** Cured / On going treatment

**Herpes Zoster** Yes / No
- **If yes, date of illness**
- **Part of body affected**

**Hypertension** Yes / No
- **If yes, when detected**
- **Current treatment**

**Asthma** Yes / No
- **If yes, when detected**
- **Current treatment**

**Allergies** Yes / No
- **If yes, state of last reaction**
- **Cause of reaction**

**Major Surgeries** Yes / No
- **If yes, type of surgery**
- **Date of surgery**
- **Outcome of surgery**

**Any Heart Disease** Yes / No
- **If yes, what disease?**
- **Current Treatment**

**Any Dietary Restrictions** Yes / No
- **If yes, state restriction**

**Please Note:** The applicant is responsible for maintaining any dietary restrictions.

### III. DECLARATION

I declare that all the information provided herein is true to the best of my knowledge.

**Signature** ____________________________ **Date** _____________
### SECTION B
**TO BE COMPLETED BY A REGISTERED MEDICAL OFFICER OR DOCTOR**

#### IV. VARIOUS TESTS

<table>
<thead>
<tr>
<th>(i) GENERAL APPEARANCE</th>
<th>(ii) CARDIO-RESPIRATORY SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Pulse Rate</td>
</tr>
<tr>
<td>Lymphnode Palpable</td>
<td></td>
</tr>
<tr>
<td>Skin Appearance</td>
<td></td>
</tr>
<tr>
<td>Throat Tonsils</td>
<td></td>
</tr>
<tr>
<td>Teeth Dentition</td>
<td>Carious</td>
</tr>
<tr>
<td>EARS:</td>
<td></td>
</tr>
<tr>
<td>Rt Hearing</td>
<td>Drum Membrane</td>
</tr>
<tr>
<td>Lt Hearing</td>
<td>Drum Membrane</td>
</tr>
<tr>
<td>EYES:</td>
<td></td>
</tr>
<tr>
<td>Rt VA</td>
<td>Squint</td>
</tr>
<tr>
<td>Lt VA</td>
<td>Squint</td>
</tr>
</tbody>
</table>

#### V. LABORATORY INVESTIGATIONS

<table>
<thead>
<tr>
<th>(i) BIOCHEMICAL</th>
<th>(ii) IMMUNOLOGY</th>
<th>(iii) HEMATOLOGY</th>
<th>(iv) PARASITOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting Blood Sugar</td>
<td>VDRL Reaction if +ve treatment</td>
<td>Haemoglobin</td>
<td>Stool Routine Examination</td>
</tr>
<tr>
<td>Serum Creatinine</td>
<td>Widal Reaction if +ve treatment</td>
<td>White Cells Count</td>
<td>Treatment</td>
</tr>
<tr>
<td>Serum Aspartate T.</td>
<td>Contact with Human Immunodeficiency Virus</td>
<td></td>
<td>Urinalysis &amp; Sediment Microscopy</td>
</tr>
<tr>
<td>Serum Alanine T.</td>
<td>Sero conversion (Optional)</td>
<td></td>
<td>Blood Smear for Protozoa, Hemoflagellates &amp; Spirochaetae</td>
</tr>
<tr>
<td>Blood Urea</td>
<td></td>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>Uric Acid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### VI. OTHER OBSERVATIONS

Any other observations whether irritable or aggressive:

#### VII. DECLARATION

I Dr. __________________ of __________________ has examined the named candidate and conclude that the candidate is / is not suitable to attend a Diploma or Degree programme at Kilimanjaro Christian Medical University College.

Signature with Official Stamp ___________________________ Date __________________