APPLICATION FORM FOR ADMISSION TO PHD PROGRAMMES - ACADEMIC YEAR 2021/2022

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, 2021.

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)
x) TOEFL iBT TM score of 65 and above (non-English speaking)
xii) 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) 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) A C A D E M I C 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.

<table>
<thead>
<tr>
<th>SECTION A</th>
<th>(TO BE COMPLETED BY THE APPLICANT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Please Write in Block Letters] I. PERSONAL INFORMATION</td>
<td></td>
</tr>
<tr>
<td>Full Name</td>
<td>First:</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Gender</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 __________________________________

(II) MUSCULO-SKELETAL SYSTEM

Any Deformity? Yes / No
If yes, which part of the body ________________________
When acquired __________________________
Use of accessories or aids ____________________________

(III) OTHER CHRONIC CONDITIONS

Diabetes Mellitus Yes / No
If yes, when detected ______________________________
Current Status ____________________________________

Tuberculosis Yes / No
If yes, when 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, date 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 _________ Weight _________</td>
<td>Lung Fields _______ Breast Lumps _________</td>
</tr>
<tr>
<td>Blood Pressure _______ Pulse Rate _______</td>
<td>Heart Size _______ Heart Sounds _________</td>
</tr>
<tr>
<td>Lymphnode Palpable _________</td>
<td>(CHEST X-RAY FILM &amp; REPORT ARE NEEDED)</td>
</tr>
<tr>
<td>Skin Appearance _________</td>
<td>(iii) ABDOMINAL EXAMINATION</td>
</tr>
<tr>
<td>Throat Tonsils _________ Carious _________</td>
<td>(ABDOMINAL U.S.S. REPORT IS NEEDED. IF MASS DETECTED)</td>
</tr>
<tr>
<td>Teeth Dentition _________ Carious _________</td>
<td></td>
</tr>
<tr>
<td>EARS:</td>
<td></td>
</tr>
<tr>
<td>Rt Hearing _______ Drum Membrane _________</td>
<td></td>
</tr>
<tr>
<td>Lt Hearing _______ Drum Membrane _________</td>
<td></td>
</tr>
<tr>
<td>EYES:</td>
<td></td>
</tr>
<tr>
<td>Rt VA _______ Squint _________</td>
<td></td>
</tr>
<tr>
<td>Lt VA _______ Squint _________</td>
<td></td>
</tr>
</tbody>
</table>

#### (iii) ABDOMINAL EXAMINATION

- **(ABDOMINAL U.S.S. REPORT IS NEEDED. IF MASS DETECTED)**

#### (IV) MUSCULO SKELETAL SYSTEM

- **Any Deformation? Yes / No**
- **If yes which part of the body**
- **Type of deformity**

#### V. LABORATORY INVESTIGATIONS

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