Saint John of God College of Health Sciences

P.O. Box 744, Mzuzu, Malawi
Tel: (265) 1 611 495/690 Fax: (265) 1 311 213
E-mail: collegehs@sjog.mw
Web: www.sjog.mw

APPLICATION FORM

COURSE APPLYING FOR: **Ref No**

- ☐ Diploma in Clinical Medicine (DCM 24)
- ☐ Diploma in Clinical Medicine – Upgrading (DCM – U 24)
- ☐ Bachelor of Science in Psychotherapy (BSPY 24)
- ☐ Bachelor of Science in Nursing & Midwifery – (BSNM 24)
- ☐ Bachelor of Science in Mental Health Psychiatric Nursing - Upgrading (MHPN 24)
- ☐ Bachelor of Science in Clinical Medicine (Mental Health) – Upgrading (CMMH 24)
- ☐ University Certificate in Midwifery (UCM 24)

READ THE APPLICATION INSTRUCTIONS BEFORE COMPLETING THIS FORM.

COMPLETE ALL APPROPRIATE SECTIONS IN CAPITAL/BLOCK LETTERS AND RETURN YOUR FORM AND OTHER SUPPORTING DOCUMENTS TO:

The Registrar
St. John of God College of Health Sciences
P.O. Box 744
Mzuzu - MALAWI
TEL : (265) 0111 610 495/690
FAX : (265) 01 311 213
E-MAIL: collegehs@sjog.mw

2 PASSPORT SIZE PICTURES

1. PERSONAL DETAILS

Name:

Mr/Mrs/Miss/Sr/Br

_____ _____

Surname First Names

Other Details:

Date of Birth: _____ Gender: Male ☐ Female ☐

Marital Status: _____

Citizenship_____ National ID No_____

If Non-Malawian provide a photocopy of passport together with registration form.

Permanent Address: _____

_____

_____

_____

_____

Cell phone Number: _____

E- mail: _____

Contact Address (if different from above)

_____

_____

_____

Fax: _____ Cell: _____

Indicate if this is your first application

Yes	
No	

If No, indicate why you were left during the first time.

_____

_____

2. NEXT OF KIN OR GUARDIAN

Name: _____ Relationship to Applicant: _____

Address: _____

_____

_____

Fax: _____ Tel: _____

E-mail: _____

3. EDUCATION HISTORY

(a) MSCE/IGCSE GRADES OBTAINED

MSCE SUBJECTS	**SCORES/GRADES**
ENGLISH	
MATHEMATICS	
BIOLOGY	
PHYSICAL SCIENCE	
PHYSICS	
CHEMISTRY	
BIBLE KNOWLEDGE	
SOCIAL STUDIES	
AGRICULTURE	
CHICHEWA	
GEOGRAPHY	
OTHER (SPECIFY……	

(b) PLEASE LIST ALL SECONDARY AND POST- SECONDARY INSTITUTIONS ATTENDED IN THE FOLLOWING SECTION, ATTACH AN EXTRA PAGE IF NECESSARY.

Name of School or College	Year of Attendance	Name of Certificate/Diploma/Degree

4. SPONSORSHIP

How will your study be sponsored? Self - Sponsored ☐ Have a Sponsor ☐ (Give details below)

Name of Sponsor: _____

Contact Address: _____

_____

Tel: _____ E-mail: _____

5. REFEREES: Give three traceable referees - **one** should preferably be from your Employer if working in public or private sector.

Name of Referee	Contact Address/Phone Number and E-mail

6 APPLICATION CHECKLIST

Please be sure to enclose the following items. Tick in the applicant box if enclosed.	For applicant	For official use only
1. Certified copies of all secondary or post secondary Certificates/Diplomas/Degree. International students should arrange with their previous college(s) for academic transcript(s).		
2. Certified copy of registration certificate with regulatory body of your country (NMCM and Medical Council if applicable).		
3. Three letters of recommendation (from current or former employer).		
4. Two passport sized photographs. (Write your names on reverse side)		
5. A photocopy of National ID for Malawians/passport for international students		
6. Proof of ability to pay fees (attach a letter from a parent/guardian/sponsor confirming sponsorship)		
7. Those employed by the Government should come with a letter of approval to pursue the course.		
8. Completed and certified medical history and examination form		
9. Authentic bank deposit slip	.	
10. Completed and signed application form		

I hereby certify that the information given in this application form is correct and complete to the best of my knowledge, and hereby give my permission to the admissions committee to obtain any verification deemed necessary to process my application. I also certify that all attached documents become the property of the College and shall not be returned to me.

Signature: _____ Date: _____

NOTE: Those who qualify will be short listed and be called for an interview.
International students will be required to send more detailed information for the recruitment panel to scrutinize.

8. FOR OFFICIAL USE ONLY

Accepted ☐ Not accepted ☐

If not accepted (Reasons)
Student number: _____

Signature of Registrar: _____Date: _____

SAINT JOHN OF GOD COLLEGE OF HEALTH SCIENCES

MEDICAL EXAMINATION REPORT FORM FOR STUDENTS

PART I: TO BE COMPLETED BY APPLICANT IN THE PRESENCE OF MEDICAL EXAMINER

First Name: _____ **Middle Name:** _____

Surname: _____ **Date of Birth:** ____/_____/20___.

Gender: ☐ **Male** ☐ **Female** ☐**Other**

National Identity Number: _____

Passport Number: _____

Nationality: _____

Address:_____
_____
_____

DECLARARTION

I, the undersigned, do herby certify that I have fully considered my answers to questions below and that to the best of my knowledge and belief, the information given is complete and correct.

_____ _____

(Date) **(Signature of the bearer)**

1. **Have you ever suffered from any of the following? (give dates for each " YES" answer. (Tick Appropriate box)**

	ITEM	YES	NO	DATE
A	**NEUROLOGY**			
1	Seizure/fits/convulsions			
2	Loss of consciousness			
3	Severe headache/ migraine			
4	Head injury/concussion			
5	Any other nervous trouble			
6	Depression			
7	Any other mental illness			
B	**PULMONARY**			
1	Tuberculosis of the Lungs			

2	Bronchitis/Pneumonia/Pleurisy			
3	Asthma or Hay fever			
4	Silicosis			
5	Any other pulmonary disease			
C	**CARDIOVASCULAR**			
1	Heart Disease "weak or strained heart			
2	Fainting attacks or dizziness			
3	Rheumatism or Rheumatic fever			
4	Pain in the chest, throat or arm while undertaking physical effort			
5	Sickle Cell Disease			
6	Leukaemia			
7	Bleeding disorders			
8	Varicose veins			
9	Any other cardiovascular disease			
	GASTRO-INTESTINAL			
1	Stomach or bowel complaints			
2	Indigestion or peptic ulcers			
3	Attacks of abdominal pains			
4	Any other gastrointestinal disease			
	RENAL			
1	Kidney failure			
2	Syphilis			
3	Gonorrhoea			
4	Difficulty or pain in passing urine			
5	Gallstones			
6	Schistosomiasis			
7	Any other renal problems			
	INTERGUMENTARY			
1	Albinism			
2	Any skin disease			
	MUSCULOSKELETAL			
1	Fractured bones			
2	Osteomyelitis			
3	Any other musculoskeletal disease			
	EYES			
1	Vision impairment			
2	Any other eye problems			

2. Have you ever undergone any operation? Yes/No

a. If yes (specify):

_____

_____

_____

_____

PART II: TO BE COMPLETED BY THE MEDICAL EXAMINER

Height: _____ **Weight:** _____ **BMI:** _____

MUAC: _____ **BP:** _____ **PR:** _____ **RR:** _____

1. **Any physical abnormalities or deformity detected? Yes/No**
   If yes (specify):
   _____
2. **Mental State Examination**
   a. Appearance and Behaviour
      _____
      _____
   b. Speech
      _____
      _____
   c. Mood
      _____
      _____
   d. Thought
      _____
      _____
   e. Perception
      _____
      _____
   f. Cognition
      _____
      _____
3. **Vision examination**
   a. Right eye without glasses _____
   b. Right eye with glasses: _____
   c. Left eye without glasses: _____
   d. Left eye with glasses: _____
4. **Hearing**
   a. Right ear
      i. Weber's test: _____
      ii. Rinne's test: _____
   b. Left ear
      i. Weber's test: _____
      ii. Rinne's test: _____

5. **CARDIOVASCULAR EXAMINATION**
   a. Heart
      i. Position & apex beat_____
      ii. Sounds: _____
      iii. Rhythms:_____
   b. Blood group type: _____
   c. Full blood count (FBC)/ Haemoglobin level: _____.

6. RESPIRATORY EXAMINATION

a. Inspection:_____
b. Palpation:_____
c. Percussion:_____
d. Auscultation:_____

7. ABDOMINAL EXAMINATION:

a. Inspection:_____
b. Palpation:_____
c. Percussion:_____
d. Auscultation:_____

PART III: CERTIFICATE

1. From your observation and examination do you consider that the candidate is in good health and fit to study? **YES / NO.**

2. Is the candidate free from any mental or physical defect likely to be aggravated or to endanger the life, health or safety of himself/herself or others in the course of training? _____

   Date: _____

   (Full Name and Qualification of The Medical Practitioner in Block Letters)

   Full Name: _____

   Registration No.: _____

   Address: _____
   _____

Official Stamp/Seal of the government/CHAM Hospital

Signature: _____