Kirai Plaza 1st Floor,
Magadi Rd, (Opp. Laiser Hill Academy)

https://www.elmahcollege.ac.ke
P.O Box 38687-00100 Nairobi

info@elmahcollege.ac.ke

+254 759 784639 | +254 736 273237

ELMAH COLLEGE
OF HEALTH STUDIES

APPLICATION FORM

Instructions

The form should be filled in **BLOCK LETTERS ONLY.**

The filled form can be scanned and submitted online as an attachment to this email; **info@elmahcollege.ac.ke** or dropped to the college at **2nd Floor Kirai Plaza, Magadi Road,LaiserHill area Ongata Rongai** together with the proof of payment of **application fees**

PERSONAL INFORMATION:

1. Full Legal Name: …………………………………………………Last/Family Name: … ………………………
2. Gender: …………………………
3. Birth date ………………………
4. Marital Status: ………………………
5. Citizenship: ……………………………………………………………
6. ID/Passport Number:…………………………………………… (All *applicants for Caregiving and Home-based care courses must be aged 18 years and above)*
7. Permanent Address: …………………………………………………
8. Telephone Number…………………………………………………
9. E-mail Address   …………………………………………………

Education Background
Please list school attended and qualifications attained

Name of School	Qualification	Year Graduated

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Course Information

Choose by ticking the box, the course you are applying for.

Certificate Courses

1. Caregiving (*KCSE Certificate*) [ ]

2. Home Based Care (KCPE and Above) [   ]

3. Community Health (KCSE D+ or KNQF Level IV equivalent) [ ]

Short Courses

1. Design Thinking for Health [ ]
2. Psychological First Aid   [   ]
3. Basic First Aid (Individual and groups) [   ]
4. Basic Life Support

We would like to know how you came to learn about the courses offered at this College.

Word of mouth/Referral [   ] Social media [ ]   Website [   ]   Location visit [ ]

Fees Information

Who will be responsible for paying fees for your studies?

Parent/Guardian [   ]   Self [   ]   Others [   ]

If payment is made by someone else, please provide details of the sponsor/sponsoring organization.
Name ……………………………………………………………………………………

Telephone (Office)…………………………   Cell phone No…………………………
Home Tel………………………………   Email Address …………………………

Postal Address ………………………   Code………………………………………
Town ………………………………………

Attach proof of payment of the **application fee of KSH.1000** (MPESA confirmation message or Bank slip) to ELMAH College of Health Studies

Payment Instruction

MPESA PAYBILL	BANK DEPOSIT
Business No. **522533 (KCB)** Account No. **7925891** **Send MPESA message or receipt to 0759784639 Or 0736273237**	Bank Name: **KCB Ongata Rongai** Account Name: **ELMAH COLLEGE OF HEALTH STUDIES** Account Number:**1334557187**

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Disability Assessment (*This information is for planning purposes and not as criteria for selection*)

Do you consider yourself as a person with a disability? [ ]**YES**   [ ]**NO**

Type/ Class ……………………………………

Give details of the nature of your disability ………………………………………………

Declaration

I declare that the information given herein is true and accurate to the best of my knowledge and I fully understand that any information found to be false will lead to automatic disqualification from consideration for admission.

Your signature below.

Declares that all information in this application (including any supplemental information) is factually true and honestly presented and that you are the person submitting this application.

Signature ………………………   Date …………………………