AlphaTech TRAINING INSTITUTE
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ADMISSION APPLICATION FORM

TO BE DULY FILLED BY THE APPLICANT			FORM A/1
Full Names ID/PP.			
No:			
Date Of Birth:			
Postal Address:			
E-Mail Address:			
Telephone:			
High School Name:			
K.C.S.E Grade:			
Course of Interest:			
Course Level:	Diploma	Certificate	Short Course
Mode of Study	Regular	Part-time	

Course Durations: Diploma: 3 Academics Years, Certificate:1 Academics Year, Short Course: 3 months

Mode of Study: Regular: 8am – 4pm Part time: 5.30pm – 8pm

I certify that the information I have given is true and correct.

Signature ……...Date: ……...

GUARANTEE OF PAYMENT OF FEES **FORM B/1**

(To be completed by Parent/Guardian)

Full Names	
ID/PP.No:	
Nationality	
Postal Address	
E-Mail Address	
Phone Number	

Agree to pay the financial requirements of

……

(Name of Student)

Relationship to student: ……..... Signature…….....Date:……..

College Attendance requirements

As per the exam regulations, each student is required to have attained an average class attendance of 75% and over to qualify for the semester's exam. Therefore, ensure the student does not miss classes.

Signature:…….…….....Date: …….……

MEDICAL EXAMINATION REPORT FORM B/2

Part 1: To be completed by the applicant

Full Names:	
Date of Birth:	
Gender:	
ID/PP. No:	
Nationality:	
Postal Address:	
E-Mail Address:	
Phone Number:	

In case of emergency, the following person should be notified;

Full Names:	
Relationship to applicant:	
ID/PP. No:	
Postal Address:	
E-Mail Address:	
Phone Number:	

Have you ever been admitted to hospital?	Yes: ☐ No: ☐ If yes, state reason for admission ....
Do you suffer from any physical disability?	Yes: ☐ No: ☐ If yes, state reason for admission ....

Do you suffer allergic from any reactions?	Yes: ☐ No: ☐ If yes, state reason for admission ....
Are there any other relevant details of your medical history not covered by this page?	Yes: ☐ No: ☐ If yes, state reason for admission ....

Applicant's Signature:…….....…Date: ….....….……

MEDICAL EXAMINATION REPORT **FORM B/3**

Part 2: To be completed by the examiningmedicalofficer

Height:	Weight:
Visual acuity:	WithoutglassesR.6/L.6/:
	WithglassesR.6/L.6/:
Hearing:	Right ear :
	Left ear :
Lymphatic glands :	
Circulatory system :	
Pulse:	
Blood pressure :	
Respiratory system :	
Abdomen :	
Spleen :	
Any evidence of hernia :	
Any other observation of importance (e.g. physical or mental disabilities) :	

Signature of physician:…….....…Date: ……..……..

Qualification…….…… ……..……

Address:…….…… .....…….……

Stamp