THE ALLIED HEALTH PROFESSIONALS COUNCIL

Passport Photo

P.O BOX 7272 KAMPALA

CONTACTS 0393242736, 0706345688

www.ahpc.ug

OFFICIAL USE

Status: ………………………………
Amount: ……………………………
Signature: ……………………………

APPLICATION FORM FOR EXTRACT FROM THE REGISTER

BIO INFORMATION

Surname: ………………………………………… First Names: …………………………………………………

Other Names: ………………………………………

CONTACT INFORMATION

Postal Address: ……………………………………………………………………………..

Email: ………………………………………...   Tel No: …………………

CURRENT EMPLOYMENT

Facility Name	Facility Type	District	Employment Type

REGISTRATION INFORMATION

Registered Title or Cadre: ………………………………………………………………….

Registration Number: …………………….. Registration date: ………………………….

TRAINING INFORMATION

Qualification: …………………………………………………………………………

Training Institution: ……………………………………………………………………..

Date of completion: ……………………............

ADDITIONAL QUALIFICATION

Qualification: …………………………………………………………………………

Training Institution: ……………………………………………………………………..

Date of completion: ……………………............

Signature: ……………………………………..   Date: ……………………………