KENYA PAEDIATRIC FELLOWSHIP PROGRAM (KPFP)
SPONSORSHIP APPLICATION FORM

Prerequisites for KPFP Fellowship sponsorship: (tick all applicable fields)

1. Working in a Government/Public Hospital ☐
2. Committed to work in Government/Public Hospital post-training for duration bonded by course of interest ☐

All applicants are required to attach the following documentation:

1. Completed application form (see below) endorsed by County authorizing official ☐
2. Personal statement indicating your interest in the course ☐
3. Full curriculum vitae ☐
4. Copies of relevant academic certificates and transcripts ☐
5. Copy of national identity card ☐
6. Copy of employment number ☐

NOTE: An application that does not comply with the above requirements will be regarded as incomplete.

APPLICANT INFORMATION		**APPLICATION DATE:**
First Name:	Surname:	Preferred name:
Home Address:		Postal Code:
County:	Town/City:	Affiliated Public Hospital: _____ Number of years worked in named hospital: _____ For Paediatricians, also indicate number of years worked with Government of Kenya post specialization _____ Current Area/Department of Work: _____ Employment DC/NCK Licence No: _____ KMPDC Registration No: _____ Current Job Group: _____ Current Gross Monthly Salary in KSH: _____
Phone No:	E-mail Address:	
Sex: Male ☐ Female ☐	Date of Birth: /dd/mm/yr /	
Date available for training: /dd/mm/yr /	Specialty or Sub-speciality applied for: Indicate Training Institution applied with:	

Emergency contact details (should we need to contact you urgently)		
First Name:	Surname:	Title:
1st Contact No:	2nd Contact No:	
Email:	Relationship to applicant: e.g. spouse, mother, father, brother, sister, aunt, colleague, etc.:	

FUNDING: Tick appropriately	
Do you have any other funding source to cover tuition either partially or fully?	YES ☐ NO ☐
If Yes, indicate how much is this other funding and source	

ACADEMIC HISTORY: TERTIARY EDUCATION			
UNIVERSITY/COLLEGE, COUNTRY:	**START DATE**	**DATE OF COMPLETION**	**DEGREE/DIPLOMA ATTAINED**

ANY ADDITIONAL QUALIFICATON ATTAINED			
TRAINING INSTITUTION, COUNTRY:	**START DATE**	**DATE OF COMPLETION**	**QUALIFICATION ATTAINED**

NAME OF RECOMMENDING SUPERVISOR AT THE PUBLIC HOSPITAL YOU ARE CURRENTLY STATIONED	
Title:	Full Name:
Designation:	Phone No: ( )
Email Address:	Department:

REFERENCES *Please list 2 professional references*	
1. Title:	Full Name:
Organization:	Phone No: ( )
Email address:	Job title:
2. Title:	Full Name:
Organization:	Phone No: ( )
Email Address:	Job title:

CURRENT AND PREVIOUS EMPLOYMENT (Note: Start with the most current)	
1. Organization:	From: (month/year): / To:(month/year): /
Job Title:	Supervisor:
Responsibilities:	
May we contact your previous employment for a reference? YES ☐ NO ☐	Phone No: ( )
2. Organization:	From: (month/year): / To: (month/year): /
Job Title:	Supervisor:
Responsibilities:	
May we contact your previous employment for a reference? YES ☐ NO ☐	Phone No: ( )

3. Organization:	From: (month/year): / To: (month/year): /
Job Title:	Supervisor:
Responsibilities:	
May we contact your previous supervisor for a reference? YES ☐ NO ☐	Phone No: ( )

COUNTY PRE-AUTHORIZATION FOR RELEASE

THE COUNTY GOVERNMENT ***Statement of Release by County Authorizing Officer:*** I hereby confirm that upon successful admission to the course applied for, _____ County hereby commits to bond and release _____for Training in_____ for a period of _____years from _____to _____	
Authorizing Officer's Name:	**Designation of authorizing officer:** **Department of authorizing officer:**
Official County Stamp:	**Date:**

After filling, download the form, have it signed and stamped by the County Authorizing Officer, scan and then e-mail fully completed application to the chosen training institution.

DISCLAIMER AND SIGNATURE	
I hereby, certify that I have provided accurate information in this application. If this application leads to a fellowship sponsorship, I understand that false or misleading information in my application or interview may result in my release.	
Signature of the Applicant:	**Date:**