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**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

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

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| **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: | | |

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

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| **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.: | |

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| **ACADEMIC HISTORY: TERTIARY EDUCATION** | | | | | | |
| **UNIVERSITY/COLLEGE, COUNTRY:** | | **START DATE** | **DATE OF COMPLETION** | | **DEGREE/DIPLOMA ATTAINED** | |
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| **ANY ADDITIONAL QUALIFICATON ATTAINED** | | | | | | |
| **TRAINING INSTITUTION, COUNTRY:** | **START DATE** | | | **DATE OF COMPLETION** | | **QUALIFICATION ATTAINED** |
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| **NAME OF RECOMMENDING SUPERVISOR AT THE PUBLIC HOSPITAL YOU ARE CURRENTLY STATIONED** | | | |
| Title: | Full Name: | | |
| Designation: | | Phone No: | ( ) |
| Email Address: | | Department: | |

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

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| **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: ( ) |
| 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: ( ) | | | | YES | NO | Phone No: ( ) |
| 1. 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**

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| **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** (A*uthorization to be sought only from any of these officers; County Executive Committee Member-Health, Chief Officer of Health, County Secretary):*  **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.**

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| **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:** |