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**KENYA PAEDIATRIC FELLOWSHIP PROGRAM (KPFP) SPONSORSHIP APPLICATION FORM**

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

1. Area of work:
* Working in a Government Hospital, (priority to KPFP phase 1 beneficiary facilities), faculty in University of Nairobi, Aga Khan University, Moi University, Gertrude’s/other public medical training institution, NEST sites, College of Paediatrics sites, National/County teaching & referral hospitals, FBO hospitals. 
* Eastern Africa region (Uganda, Tanzania, Ethiopia, Sudan, South Sudan) and ELMA supported countries (Malawi, Rwanda) Applicable to **Doctors** only. 
1. Committed to complete training and bonding in the area of bonding without defaulting 

# All applicants are required to attach the following documentation:

1. Completed KPFP sponsorship application & bonding forms; pre-authorization (during the application), release & bonding (once admitted)
2. Personal statement/reflective thinking summary about your passion for the course and desired impact post-training
3. Updated curriculum vitae
4. Copies of relevant academic certificates, licenses, and transcripts
5. Copy of national identity card/passport

#  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:  |
|  Country:  County:  | Town/City: | Affiliated Hospital/Institution:Number of years worked in named institution: For Paediatricians, also indicate number of years worked with the preauthorizing institution post specializationCurrent Area/Department of Work: Employment/Licence No: Country regulatory body registration No:Current Job Group (if applicable): Current Gross Monthly Salary in KSH: |
| Phone No: | E-mail Address: |
| Sex: Male | Female |  National ID No/Passport No: Date of Birth: /dd/mm/yr / Age (Years):  |
| Date available to begin 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 training costs either partially or fully? If Yes, indicate how much this other funding is and the 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 HOSPITAL/INSTITUTION 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: ( ) |

 **PRE-AUTHORIZATION FOR RELEASE**

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| **THE PREAUTHORIZING ENTITY*****Statement of Release by Authorizing Officer:***I hereby confirm that upon successful admission to the course applied for, (*fill in the name of preauthorizing entity*) hereby commits to bond and release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*fill in the name of the candidate*) for Training in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*fill in the name of the course*)for a period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Authorizing Officer’s Name:**  | **Designation of authorizing officer:** **Example:** County employees should seek authorization from either *County Executive Committee Member-Health, Chief Officer of Health, or County Secretary***Department of authorizing officer:** |
| **Official Stamp of the preauthorizing officer:** | **Date:** |

**After filling, download the form, have it signed and stamped by the 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 training sponsorship: * I understand that false or misleading information in my application or interview may result in my dismissal. Agree Disagree
* I understand that I am expected to complete the training and bonding without defaulting Agree Disagree

KPFP is committed to maintaining the highest degree of ethical conduct and integrity. Direct or indirect canvassing will lead to automatic disqualification. In case of any demands for bribe, kickback, payment, gift, favours, or thing of value in connection with preauthorization/release and bonding write to *kpfp@kenyapaediatric.org*  |
| **Signature of the Applicant:** | **Date:** |