



# RUAHA CATHOLIC UNIVERSITY (RUCU)

Former Ruaha University College (RUCO)

P.O. BOX 774 IRINGA- TANZANIA

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## APPLICATION FORM FOR ADMISSION CERTIFICATE AND DIPLOMA PROGRAMMES 2016/2017

### I: PROGRAMMES

Please tick the programme you are applying for under the choice boxes, Indicate your choice priority.

#### A. DIPLOMA PROGRAMMES.

No.	Programme Name	Duration	1 <sup>st</sup> Choice	2 <sup>nd</sup> Choice	3 <sup>rd</sup> Choice
1	Diploma in Computer Science	2 years			
2	Diploma in Medical Laboratory Sciences	3 years			
3	Diploma in Pharmaceutical Sciences	3 years			
4	Diploma in Law	2 years			
5	Diploma in Business Administration	2 years			
6	Diploma in Library Information Studies	2 years			

#### B. CERTIFICATE PROGRAMMES.

No.	Programme Name	Duration	1 <sup>st</sup> Choice	2 <sup>nd</sup> Choice	3 <sup>rd</sup> Choice
1	Certificate in Computer Science	1 year			
2	Certificate in Medical Laboratory	2 years			
3	Certificate in Law	1 year			
4	Certificate in Business Administration	1 year			
5	Certificate in Library Information Studies	1 year			

### II: PERSONAL INFORMATION

[Please write in Block Letters]			
First Name		Postal Address	
Middle Name		City	
Surname		Religion	
		Country	
Gender		Phone number	
Marital Status		Mobile Number	
Date of Birth		e-mail Address	
Place of Birth			
Tribe			

III. EDUCATIONAL BACKGROUND					
Name of Institution/School	Years Attended	Areas of Specialization	From	To	Awards

IV. FINANCIAL SUPPORT FOR STUDIES			
Sponsor Name			
Postal Address			
City, Region, Country			
Phone Number		Fax Number	

V. EMERGENCY CONTACT			
1) Contact Name		2) Contact Name	
Relation		Relation	
Postal Address		Postal Address	
Phone Number		Phone Number	
Fax Number		Fax Number	

VI. PERSONAL REFEREES	
Name and Addresses of three referees who are familiar with your academic ability and performance:	
1) Contact Name	
Relation	
Postal Address	
Phone Number	
Fax Number	
E-mail Address	
2) Contact Name	
Relation	
Postal Address	
Phone Number	
Fax Number	
E-mail Address	

VII. DECLARATION	
All the information provided herein is true to the best of my knowledge and belief.	
Signature _____	Date: _____

# MEDICAL EXAMINATION FORM

This form consists of Section A to be completed by the applicant and Section B to be completed by a registered Medical officer or doctor. The completed form must be submitted along with all the other application materials.

## SECTION A: (TO BE COMPLETED BY THE APPLICANT)

[Please, Write in Block Letters]				I. PERSONAL INFORMATION			
Full Name	First:	Middle:	Last:	Marital Status			
Date of Birth				Programme			
<b>II. PAST MEDICAL HISTORY</b>							
<b>(I) NERVOUS SYSTEM</b>				<b>Herpes Zoster</b> Yes/No			
<b>Any loss of consciousness?</b> Yes/No				If yes, date of illness:			
If Yes, dates of incident:				Part of body affected:			
Current treatment:				<b>Hypertension</b> Yes/No			
<b>Any neurological deficiency?</b> Yes /No				If Yes, when detected:			
If Yes, state deficiency				Current treatment:			
When acquired:				<b>Asthma</b> Yes /No			
Current treatment:				If Yes, when detected:			
<b>Any fits?</b> Yes/No				Current treatment :			
If Yes, type of fits:				<b>Allergies</b> Yes/No			
Date of last episode:				If Yes, date of last reaction:			
Current treatment:				Causes of reaction:			
<b>(II) MUSCULO-SKELETAL SYSTEM</b>				<b>Major Surgeries</b> Yes/No			
<b>Any deformity?</b> Yes/No				If Yes, type of surgery:			
If yes, which part of the body:				Date of surgery:			
When acquired?				Outcome of Surgery:			
Use of accessories or aids:				<b>Any Heart disease</b> Yes /No			
<b>(III) OTHER CHRONIC CONDITIONS</b>				If Yes, what disease?			
<b>Diabetes Mellitus</b> Yes/No				Current treatment:			
If Yes, when detected?				<b>Any Dietary Restrictions</b> Yes /No			
Current status:				If yes, state restrictions:			
<b>Tuberculosis</b> Yes/No				<b>Please Note: The applicant is responsible for maintaining any dietary restrictions.</b>			
If yes, when detected:							
Current status: Cured/On going treatment							
<b>III. DECLARATION</b>							
I declare that all the information provided herein is true to the best of my knowledge.							
Signature: _____				Date: _____			

**SECTION B:(TO BE COMPLETED BY A REGISTERED MEDICAL OFFICER OR DOCTOR)**

**IV. VARIOUS TESTS**

<b>(I) GENERAL APPEARANCE</b>		<b>(II) CARDIO-RESPIRATORY SYSTEM</b>	
Height:	Weight:	<b>(CHEST X-RAY FILM&amp;REPORT ARE NEEDED)</b>	
Blood Pressure:	Pulse Rate:	Lung Fields:	Breast Lumps:
Lymphnode Palpable		Heart Size:	Heart Sound:
Skin Appearance		<b>(III) ABNOMAL EXAMINATION</b>	
Throat Tonsils		<b>(ABNOMAL U.S.S REPORT IS NEEDED. IF MASS DETECTED FILM IS NEEDED)</b>	
Teenth Dentition:	Carious:		
EARS:		Contour: Sunken / Normal /Distended	
Rt Hearing:		Skin Scar	
		Umbilicus:	Hernia:
EYES:		<b>(IV) MUSCULO SKELETAL SYSTEM</b>	
Rt VA:	Squint:	Any Deformation? Yes / No	
Lt VA	Squint:	If Yes which part of the body:	
		Type of deformity:	

**V. LABORATORY INVESTIGATIONS**

<b>(I) BIOCHEMICAL</b>		<b>(III) HEMATOLOGY (CULTA COUNTER)</b>	
Fasting Blood Sugar:		Haemoglobin	
Serum Creatinine:		White Cells Count	
Serum Aspartate:		<b>(IV) PARASITOLOGY</b>	
Serum Alanine T.:		Stool Routine Examination	
Blood Urea:		Treatment	
Uric Acid:		Urinalysis & Sediment Microscopy	
<b>(II) IMMUNOLOGY</b>		Treatment:	
VDRL Reaction if +ve treatment:		Blood Smear for Protozoa, Hemoflagellets & Spirachetae:	
Widal Reaction if+ve:			
Contact with Human Immunodeficiency Virus Sero			
Conversion (optional):		Treatment:	

**VI. OTHER OBSERVATIONS**

Any other observations whether irritable or aggressive:

**VII. DECLARATION**

I Dr.----- of-----has examined the named candidate----- and conclude that the candidate is/is not suitable to attend a

three/four year degree programme at Ruaha University College-Iringa.

Signature with official stamp: -----

Date:-----