REPUBLIC OF KENYA

KMPDC
Enhancing Quality Healthcare

FORM

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APPLICATION FOR ORAL HEALTH OFFICER INTERNSHIP LICENCE

PURSUANT TO THE MEDICAL PRACTITIONERS AND DENTISTS ACT (CAP 253 – LAWS OF KENYA)

PASSPORT PHOTO

A. DETAILS OF THE APPLICANT			
SURNAME			
OTHER NAME			
DATE OF BIRTH			
NATIONALITY			
PASSPORT NUMBER			
GENDER			
POSTAL ADDRESS			
CODE		TOWN	
COUNTY			
MOBILE NUMBER			
E-MAIL ADDRESS			

DETAILS OF THE NEXT OF KIN	
FULL NAME	
RELATIONSHIP	
MOBILE NUMBER	
E-MAIL ADDRESS	

DISABILITY ASSESSMENT		
DO YOU HAVE ANY DISABILITY?	**YES**	**NO**
IF YES, PLEASE SPECIFY (ATTACH NCPWD CERTIFICATE)		

B. ACADEMIC OR PROFESSIONAL QUALIFICATIONS

EDUCATION

LEVEL	INSTITUTION	ACQUIRED QUALIFICATIONS	DATE
HIGH SCHOOL		*(include grade)*	
DIPLOMA			
OTHERS *(Specify)*			

INTERNSHIP

NAME OF INTERNSHIP TRAINING CENTRE	
E-MAIL ADDRESS	

CONFIRMATION OF REQUIREMENTS

1	CERTIFIED COPY OF PASSPORT/NATIONAL IDENTIFICATION CARD	
2	ONE CURRENT COLOURED PASSPORT SIZE PHOTOGRAPH	
3	CERTIFIED COPY OF HIGH SCHOOL CERTIFICATE	
4	COPY OF DIPLOMA/DEGREE CERTIFICATE AND TRANSCRIPTS CERTIFIED BY THE TRAINING INSTITUTION	
5	MUST APPEAR IN THE LIST SUBMITTED BY DEANS OF ACCREDITED NATIONAL COMMUNITY ORAL HEALTH TRAINING SCHOOLS	
6	EVIDENCE OF PAYMENT OF INTERNSHIP LICENSE FEE OF KSHS.3,000 ALL PAYMENTS SHOULD BE MADE ON E-CITIZEN VIA SYSTEM GENERATED INVOICE NUMBER	

C. DECLARATION BY APPLICANT

I HEREBY DECLARE THAT THE ABOVE INFORMATION IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF

SIGNATURE		DATE	DD	MM	YYYY

FOR OFFICIAL USE					
THE PROCESS WILL TAKE A MAXIMUM OF TWO WEEKS					
PREPARED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
RECOMMENDED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
APPROVED/NOT APPROVED					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY