



METHODIST COLLEGE OF HEALTH SCIENCES
MAUA Campus



PO BOX 63 - 60600, MAUA, IGENBE SOUTH
Mobile +254-0724759626 / 0724032446
Email: methodistmedicalcollege@gmail.com

APPLICATION FOR ADMISSION

Date: _____

PERSONAL DETAILS: -

Surname _____ Other Names _____
 Date of Birth _____ Nationality _____
 Gender: - Male ___ Female ___ Marital Status: - Single ___ Married ___ Other ___
 Mobile Number _____ Email address _____
 Postal Address _____ Postal Code _____ Town: _____
 Citizenship _____ ID/Passport Number _____

PERSONAL HEALTH INFORMATION:

Please describe your general health: - Excellent ___ Good ___ Fair ___ Poor ___
 Do you have any medical condition(s)? yes / no If 'yes' please explain _____

 Do you have any physical impairment(s)? yes / no If 'yes' please explain _____

 Do you have any special dietary requirement(s)? yes / no If 'yes' please explain _____

Do you, or have you ever :-

Smoked? yes / no Drunk alcohol? yes / no Used addictive drugs? yes / no

FAMILY INFORMATION:

Father's name: _____	Mother's name: _____
Address _____	Address _____
Telephone _____	Telephone _____
Email _____	Email _____
Nationality _____	Nationality _____
Occupation _____	Occupation _____
Religious affiliation _____	Religious affiliation _____

Name of legal guardian if not parent(s) _____

Occupation of legal guardian if not parent(s) _____

Address of legal Guardian(s) _____

E-mail of legal Guardian(s) _____

TYPE OF ADMISSION: [Please tick appropriately]

Learning Mode Preferred		Accommodation Type Preferred	
Full-time:	<input type="checkbox"/>	Boarder:	<input type="checkbox"/>
Distance Learning (DLM):	<input type="checkbox"/>	Day Scholar:	<input type="checkbox"/>

COURSE APPLIED FOR: _____

DECLARATION: I _____ hereby apply for admission at Methodist College of Health Sciences and confirm that the information provided above is correct to the best of my knowledge. I understand that the College reserves the right to deny or cancel admission if any information given in this form is proved false.

Reporting Date: _____ A Non-refundable Application Fee of 1,000.00 is applicable.

Where did you hear about Methodist College of Health Sciences?

Friends _____ Radio/TV _____ Career Clinic: _____ Others [Specify] _____

Who is sponsoring your course of choice? _____

Signature: _____ Date: _____

FOR OFFICIAL USE ONLY: DO NOT WRITE ON THIS SECTION

Date Applied: _____	Date Form Returned: _____
Date Application Fee Paid: _____	Receipt Number: _____
Documents Submitted: All ___ Partial ___ None ___	State Missing documents if any _____ _____
Admission Status _____	Comments: _____

This form should be returned 2 weeks before reporting date

MPESA Pay bill 960940 / Barclays Bank: 013-2307938 / KCB Bank 1210596504

Methodist College of Health Sciences: Learning to serve

Updated: March 22, 2023