KIIRUA TECHNICAL TRAINING INSTITUTE
P.O BOX 1931-60200 MERU-KENYA
Cell: 0718621864
E-Mail: kiiruatti@yahoo.com
info@kiiruatti.ac.ke
Website: www.kiiruatti.ac.ke

SECTION I:

TRAINEES PERSONAL DETAILS

Full Name: …….
P.O BOX:…….Postal code …….....
Gender…… Date of birth……Marital status: ……
ID NO: …….....
TEL NO (student's)……
Religion……..Denomination…….
County……..
Home district……..……Constituency……
Division……
Location……...Sub location…….
Village……..
Any disability/ health problem: (YES/NO) (MILD/SEVERE) (tick as applicable)

If yes Specify:

……..
……
……
Hobbies……
How did you get to know about Kiirua T.T.I? …….....

PREVIOUS ACADEMIC DETAILS

Previous Institution/School: ……..…
P.O Box…….Postal Code: ……
Highest level of education/training……
Grade obtained……
Year completed…….....

SECTION II:

FAMILY DETAILS

Father's name: ……..
ID NO……. (Attach a copy of ID card)
TEL NO……
Occupation……
Other sources of income……..
Is father alive? (YES/NO)……..…… (If no, attach evidence of death)
Mother's name……
ID NO…… (Attach a copy of ID card)

TEL NO……
Occupation……
Other sources of income……
Is mother alive? (YES/NO)……. (If no, attach evidence of death)
State who pays your fees…….
Relationship……. Occupation……. ID NO……
Address ……Telephone No……

SIBLINGS IN SCHOOL/OTHER INSTITUTIONS

	Name	School/Institution	Level
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Briefly provide any other relevant information.
……
……
……

SECTION III:
TRAINEE'S DECLARATION.
I confirm that the information given above is true to the best of my knowledge and I am aware that giving false information will lead to automatic disqualification.

NAME:……Signature……..Date……

Registrars comments……
……
……
SIGNATURE……..DATE……

KIIRUA TECHNICAL TRAINING INSTITUTE
P.O BOX 1931-60200 MERU-KENYA
Cell: 0718621864
E-Mail: kiiruatti@yahoo.com
info@kiiruatti.ac.ke
Website: www.kiiruatti.ac.ke

MEDICAL REPORT

NOTE: **Applicants must get this form filled by a Doctor from a recognized hospital. Payment for the examination is the sole responsibility of the applicant.**

NAME:……COURSE…….

ADM NO……...

1. **Eyes and vision**
   - ✓ **Unaided Right-Left……**
   - ✓ **Aided Right-Left……**
   - ✓ **Colour Blind……..**
   - ✓ **Visual field……**
2. **Nose**
   - ✓ **Nasal bleeding……**
   - ✓ **Adenoids……**
3. **Ears**
   Hearing voice -Right…….
   -Left……...
4. **Mouth and Teeth……..**
5. **Glands …….**
6. **Chest ……**
   With special reference to any tubercular tendencies……
7. **Spinal column…….....**
8. **Body internal organs……...**
   ……
   …….
9. **Any other weakness, defects or disease: e.g. Defects of speech local twitching or spasm, nervous disorder, STIs etc.**
   General observations if care is desirable in any special direction please give particulars
   ……
   ……..

Name of the registered medical practitioner……

Signature……..Official Stamp and Date……