



MWANZA COLLEGE OF HEALTH AND ALLIED SCIENCES (MWACHAS) SCHOOL OF ANESTHESIA

APPLICATION FOR ONE YEAR CERTIFICATE COURSE IN ANESTHESIA

ACADEMIC YEAR MARCH 2025 / FEBRUARY 2026.

We are happy to invite applications to study Anesthesia at MWACHAS-Bugando school of Anesthesia. Please fill in the spaces provided in the forms and submit your application to Bugando school of Anesthesia using either of the options below. The application is open from 8TH December 2024 and the **deadline** for application is February 28th 2025.

PART ONE: DETAILS OF APPLICATION

REQUIREMENTS / ELIGIBILITY:

- (a) Applicant must be a nurse or clinical officer. We do not receive applicants fresh from secondary school or professions other than the two mentioned above.
- (b) Applicant must attach all verified copies of secondary education and professional training-nursing or clinical medicine.
- (c) Applicant must attach a Medical Certificate stating the fitness of the applicant.
- (d) Photocopies of the applicant's relevant certificates including Internship certificate and registration certificate with Medical Council of Tanganyika.
- (e) Two (2) recent passport-size photos of the applicant with blue background.
- (f) A recommendation letter from the applicant's employer is an added advantage
- (g) For FOREIGNER NURSES, you must be cleared by Tanzania Nursing and Midwifery Council

APPLICATION PROCESS:

Can be done through any of the following:

- Application form well filled in and returned personally
- Delivered by post mail: address

OR;

**HEAD,
MWACHAS-BUGANDO SCHOOL OF ANESTHESIA
P.O BOX 1370,
MWANZA.**

OR;

- By email: bugandoschoolofanesthesia@gmail.com

When applying please indicate your correct email address and current phone number.

APPLICATION FEE:

Application fee of Tsh. 25,000/= (Nonrefundable) should be paid through the following bank account:

BMC VYUO COST SHARING

CRDB BANK

ACCOUNT NUMBER 01J1054747600.

Applicants who do not pay application fee will not be considered for selection!

The original copy of the payment receipt for the application fee should be attached

PART TWO: OTHER DETAILS:

1. FEES, RESIDENCE AND OTHER EXPENSES

FEE STRUCTURE ONE YEAR TRAINING IN ANESTHESIA 2025-2026.

FEE STRUCTURE S#	PAYMENT/ITEM	PAYABLE TO	AMOUNT
1	STUDENT ID	TO THE COLLEGE	20,000/=
2	CASE LOG BOOK	TO THE COLLEGE	20,000/=
3	TUITION FEE	TO THE COLLEGE	1,100,000/=
4	CAUTION MONEY	TO THE COLLEGE	50,000/=
5	EXAMINATION FEE	TO THE COLLEGE	150,000/=
6	FIELD SUPERVISION	TO THE COLLEGE	150,000/=
7	CERTIFICATE	TO THE COLLEGE	20,000/=
8	STUDENT UNION & SPORTS	TO THE COLLEGE	15,000/=
TOTAL			1,525,000/=
TOTAL COST OF FOR ONE STUDENT PER YEAR			1,525,000/=

STUDENT EXPENSES

S/N	PAYMENT/ITEM	PAYABLE TO	AMOUNT
1	STIPEND	STUDENT	3,600,000/=
2	ACCOMMODATION	STUDENT	600,000/=
3	BOOKS ALLOWANCE	STUDENT	200,000/=
4	FIELD ALLOWANCE	STUDENT	150,000/=
5	MEDICAL INSURANCE	STUDENT	50,400/=
TOTAL			4,600,400/=
TOTAL COST OF FOR ONE STUDENT PER YEAR			4,600,400/=

Money directly payable to the college should be paid through:

**BMC VYUO COST SHARING
CRDB BANK
A/C NUMBER 01J1054747600**

2. PERSONAL DETAILS:

Your name: [FIRST

NAME] _____ [MIDDLENAME] _____ [SURNAME] _____

Male/Female [M/F] ADDRESS _____ CITY _____

Mobile phone: _____

Email: _____

Work station: _____(hospital)
 Date of birth: [DD/MM/YY] ____/____/____ Place of birth _____
 Nationality_____ Passport #:_____

For Emergencies:

NAME: _____
 _____RELATIONSHIP _____
 ADDRESS _____ CITY _____
 PHONE: _____
 EMAIL: _____

3. ACADEMIC DATA

ALL SEC.SCHOOOLS ATTENDED	LOCATION	DATE: FROM (MONTH/YR)	TO (MONTH AND YEAR)	CERTIF.INDEX NO
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ALL COLLEGES/SCHOOLS	LOCATION	DATES: FROM	TO	DIPL/CERT.EARNED
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Total number of years of schooling: _____years and _____months [From secondary school].

4. LANGUAGE FLUENCY [Please put a tick for each language]

LANGUAGE	SPOKEN			WRITTEN		
	FAIR	GOOD	VERY GOOD	FAIR	GOOD	VERY GOOD

5. REFEREES

Names and addresses (email and phone numbers) of two referees who know your ability as a student and can assess your competence in written and spoken English.

a) _____ Email: _____
 Phone: _____
 b) _____ Email: _____
 Phone: _____

6. SIGNATURE AND DATE

I certify that to the best of my knowledge the information I have given above is correct.
 (Date) (Signed)

7. SPONSORSHIP.

The Sponsor should indicate here that the candidate will receive financial support for the year the applicant will spend at MWACHAS college.

NAME OF SPONSOR _____
 P.O. BOX CITY OR TOWN _____ TEL/MOBILE: _____
 BUSINESS OR ACTIVITY _____
 FAX/E-MAIL _____

I myself,
 I confirm that my organization will give full financial support to _____ during the period of his/her education at Bugando school of Anesthesia, if he/she is accepted.

(date) _____ (Signed) _____
Official stamp or seal

FOR OFFICIAL USE ONLY

PLEASE ENCLOSE PHOTOCOPIES OF ALL TRANSCRIPTS

YOU ARE MOST WELCOME.

By: HEAD BUGANDO SCHOOL OF ANESTHESIA (+255757754013)

MEDICAL CERTIFICATE

SURNAME..... OTHER NAMES.....

AGE..... SEX

MARITAL STATUSCITIZENSHIP.....

PERSONAL HISTORY

Is the examinee suffering from any of the following? Indicate Yes or No.

- Dysentery_____ Kidney or urinary disease_____
- Epilepsy_____ Psychosis _____
- Pneumonia _____ Sickle cell disease_____
- Allergic disorder_____ (mention allergen)_____
- Gastric or duodenal Ulcer_____ Jaundice _____
- Varicose Veins _____ Diabetes _____
- Deformity_____ Eye disorder _____
- Skin disease _____ Gynecological disorder _____
- Major trauma _____ Tuberculosis _____
- Pleurisy _____ Rheumatic Fever_____
- Heart Disease _____ Recurrent indigestion _____
- Ear , Nose or Throat disorder _____ Chronic Anemia _____
- Malaria _____ Major or minor operations _____
- Any other serious disorder _____ History of TB contact _____

PHYSICAL EXAMINATION

Height:_____cm Weight: _____kg. HEENT:_____

Ears(Any discharge):_____ Nose:_____

Cardiovascular: BP_____mmHg HR_____ Regular Any

murmurs:_____

Respiratory: Wheezing:_____ Breath sounds:_____ RR_____

Abdomen:_____ Hernia:_____ Masses _____ Liver _____

_____ Kidneys _____ Spleen _____

LABORATORY RESULTS

Urinalysis: Sugar _____ Bilharzia _____ Albumin _____

Stool: Worms _____

Blood:Blood Group:_____ FBP-Hb _____g/dL

Neutrophils _____ Eusinophils _____ Bisophils _____ Lympho

cytes _____

Monocytes _____ ESR _____ Platelets _____

Chest Xray:(If Indicated) _____ ECG _____

ECHO _____

CONCLUSION

I have examined Mr/Mrs/Miss/Sr/Br/Fr/Dr _____ and considered that she/he is / not physically and mentally fit to be admitted for further studies.

Name Signature Date

Title Qualifications

Address/Institution Official stamp [of hospital]