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

APPLICATION FOR ONE YEAR CERTIFICATE COURSE IN ANESTHESIA

ACADEMIC YEAR SEPTEMBER 2026 / SEPTEMBER 2027.

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 1ST JUNE 2026 and the **deadline** for application is AUGUST 31ST 2026.

PART ONE: DETAILS OF APPLICATION

REQUIREMENTS / ELIGIBILITY:

(a) Applicant must be a registered 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 OR;
- Delivered by post mail: address

  HEAD,

  MWACHAS-BUGANDO SCHOOL OF ANESTHESIA

  P.O BOX 1370,

  MWANZA. OR;
- By email: **schoolanaesthesia@bmc.or.tz OR rebbyshijjy@gmail.com**

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

APPLICATION FEE:

Application fee of Tsh.25,000/= (Non-refundable) 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 2026-2027.

PAYABLE TO THE COLLEGE

2	CASE LOG BOOK	TO THE COLLEGE	20,000/=
3	TUITION FEE	TO THE COLLEGE	1,300,000/=
4	CAUTION MONEY	TO THE COLLEGE	50,000/=
5	EXAMINATION FEE	TO THE COLLEGE	200,000/=
6	GRADUATION FEE	TO THE COLLEGE	50,000/=
6	FIELD SUPERVISION	TO THE COLLEGE	200,000/=
7	CERTIFICATE	TO THE COLLEGE	20,000/=
8	STUDENT UNION & SPORTS	TO THE COLLEGE	15,000/=
TOTAL			**1,875,000/=**

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]_____

_____

[GENDER]……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
ALL COLLEGES/SCHOOLS	LOCATION	DATES: FROM	TO	DIPL/CERT.EARNED

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 STATUS ……...CITIZENSHIP……

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] ……