MINISTRY OF HEALTH

CLINICAL OFFICERS COUNCIL

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TRAINING INSTITUTION ACCREDITATION APPLICATION FORM

BASIC INFORMATION:

Name of institution: …….....

Postal address …….....

Physical address……telephone……..mobile…....……

Date of in cooperation (attach copy certificate)…….....……..

County …….....…….

Constituency …….....

Training programmes for consideration…….....

Number and Type of programmes…….....

Proposed commencement date…….....

Name of Contact Person: …….....…….....

Designation of contact person: …….....

Telephone: …….....

Email Address: …….....

Accreditation application fee paid (attach receipt)

I hereby apply for accreditation

Name …….....

Designation ……

Signature …….…….

Date…….....