ALLIED HEALTH PROFESSIONALS COUNCIL

APPLICATION FORM FOR OPERATING A PRIVATE ALLIED HEALTH UNIT

1. Professionals Name……
2. Registered Title……..
3. Registered Number…….. Registration Date…….
4. Name of Health Unit Owner……
5. Name of health unit…….
6. Postal Address…….. Tel. No…….
7. Town/Village/Parish…… Plot No…….
   Sub county……. Street……..
   City/Town Council……District…….
8. Day Care center (Tick)
   - Medical Clinic
   - Dental Clinic
   - Ultra Sound Unit
   - Physiotherapy Unit
   - Orthopedic Clinic
   - Ophthalmic/eye Clinic
   - Psychiatric Clinic
   - Drug Shop
   - Orthopaedic Rehabilitation clinic
   - Vector control center

I hereby certify that the above information is correct Signature

applicant…… date……Note: Please attach Your Registration Certificate, valid Annual Practicing License, Valid Extract, Transcript, a fully filled and stamped checklist from the District/Divisional Allied Health Supervisor.

FOR OFFICIAL USE ONLY

Recommendation from Registrar…….....

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Signature…….. Date……