ADMISSION FORM

UNITED TANZANIA AERONAUTICS COLLEGE

AS PER TRAINING PROCEDURES MANUAL

APPLICATION FOR ADMISSION TO AIRCRAFT MAINTENANCE ENGINEERS

(AME) – PILOT PROGRAMMES.

FILL IN BY HAD

Have you previously Aviation course?

☐ No ☐ Yes

If yes, when _____

Have you ever been employed in the aviation industry specialization?

Personal data

Full legal Name _____

First Middle Last

Male ☐ Female ☐

ID/ Passport Number _____Gender

Permanent Address_____

_____

City _____ District_____ Region_____

Phone Number _____ _____

Home Mobile

E-mail _____

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b) Professional Qualifications

Name and Address of Institution	**Level of professional**	**Score**
……	……	……
……	……	……
……	……	……
……	……	……
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ATTACH TRANSCRIPTS

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Birth Date ……..

Employer / Sponsor …….

Particulars of Education and professional Qualifications

a) Education Qualification

Name and Address of Secondary School	**Subject Taken**	**Score**
O'LEVEL …… …… …… …… …… …… ……	…… …… …… …… …… …… ……	…… …… …… …… …… …… ……
A'LEVEL …… …… …… …… …… ……	…… …… …… …… …… …… ……	…… …… …… …… …… …… ……

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SPONSORSHIP

Give the full Name Address, relationship and a letter of commitment from each of your.

Sponsors

	Full Name	**Address**	**Tel Numbers**	**Relationship**
Sponsor # 1				
Sponsor # 2				
Sponsor # 3				

Declaration:

I declare that all the information given in this form is correct.

Signature of Applicant …….. Date: ……

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MEDICAL FORM

UNITED TANZANIA AERONAUTICS COLLEGE

AS PER REQUIREMENT

TRAINING PROCEDURES MANUAL AMP-001-01

MEDICAL EXAMINATION

APPLICANT FULL NAME----------

EXAMINATION DATE ----------

EXAMINATION HOSPITAL NAME ---------- LOCATION ----------

Height(m):5.8 weight(kg) Build:Slender ☐ Medium ☐ Heavy ☐ ObeseN ☐					
Head, Face, Neck and Scalp	Normal Yes	No		Normal Yes	No
Nose			Vascular system		
Sinuses			Abdomen and Viscera (including hernia)		
Month and throat			Anus and rectum (hemorrhoids, fistula, prostate)		
Ear's General (int&ext cannals)			Endocrine system		
Drums (perforation)			G.U System		
Eyes, General, Visual Field			Upper and low		
Ophthalmoscope			Spine , other musculoskeletal		
Pupils (equality and reaction)			Identifying body marks, scars, tattoos		
			Skin and lymphatic		

Other serious illnesses: ----------
Food drug other allergies: ----------
current medication: ----------
Hospitalizations, operations or serious injuries (please include dates) ----------
Other testing or counseling (include Psychiatry, Medical or education)----------
Chronic or illness (eg. asthma) : ----------
Parent's Signature: ---------- Date ----------

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PATH II PHYSICIAN'S MEDICAL EXAMINATION

This examination should be formed within 90 days preceding the opening of college

Part I parent's form should be checked with parent before the exam.

Child's

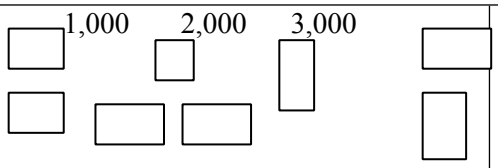
Name ----------

CODE S – Satisfactory X-Not Satisfactory O-Not Examined

Ht---------- Wt ---------- Bp ---------- Hgb ---------- UA ----------

Eye			Abdomen	
Ears			Extremities	
Nose			Posture	
Throat			Skin	
Teeth			Allergies	
Lungs			Motor coordination	
Heart			Speech	

Comments ----------

Audiometric 500 1,000 2,000 3,000  Right ear db loss Left ear db loss	Intermediated vision 100cm N- chart value Colour vision : Normal Abnormal
Prescription for correcting lenses (when required)	

LABORATORY EXAMINATION

Urinalysis Sugar N/L Albumen N/L-NIL	Blood analysis Hb130g 100cm N-Chart Value
ECG: Normal Abnormal	Chest x-ray Normal alb normal
Summary (Abnormal findings, remarks and recommendation)	

Applicant (check) is medical fit for license Is not

Ocular motility (association parallel Movement nystgmus			Neurological (specify Reflexes,equilibrium,sense,coordinate		
Lungs and heat (including breast)			Psyhiiatric(specify any personality deviation)		
Heat (thrust, size, Rtytm, Sounds) Blood pressure Recumbent systolic Systolic ☐☐☐ ☐☐ Diastolic ☐☐☐ ☐☐ ☐ Pulse: Seated MIN Hearing Whispered Conversation Voice Right 3m 6m Left ear 3m 6m			General systemic		
			Diastolic Unconnected Corrected Right eye 20/ 20/ Left eye 20/ 20/ Both eyes 2 ☐☐☐		

	0/ 20/
	Near vision 30m - 50 N – Chart value

MEDICAL EXAMINER" DECLARATION

There by certify that personally examined the applicant named on this medical examination report and that This report with any attachment embodies my findings completely and correctly ……. …… …… Place of examination Date Medical Examiner's Signature

FILL IN BY HAND

Medical Examination Initial/ Renewal			Place		Date
1. Full Name: (Block capitals, Surname First):					Mr.Mrs.Ms
2. Permanent Address:					Telephone No.
3. Postal Address (If different form above)					Telephone No
4. Place and Date of Birth	5. Age	6. Material Status S/M/W/D	7. Occupation	8. Employer:	
9. Type of license (s) held or applied for					
Airline Transport pilot	ATCO		License (Certificate) Number		Flying Time

				Total Last six months
Commercial pilot	Cabin Crew			
Flight engineer	Student Pilot			
	PPL Instrument Rating			

10. Have you previous been examined for aviation Duties	If Yes, Where and when	Were you declared FIT/UNFIT
11. Type (s) of aircraft flow last Medical Examination		
Name and address or own General practitioner		Telephone No:
12. Any medication presently being prescribed? YES/NO	IF YES, give description purpose and by whom prescribed	
Have ever been treat for alcoholism or drug addition		

MEDICAL HISTORY

15.	Medical History you ever had you now any of the following. If YES please tick and described in remark												
		Yes	No			Yes	No			Yes	No		Any other illness
a	Frequent or sever headaches			h	Stomach				Attempt			w	Is there family history of • Diabetes
b	Dizziness, Fainting Spells or Unconsciousness			i	Kidney stone or blood in urine			p	Motion Sickness Requiring Drug				Cardiovascular disease
c	Eye trouble Except glasses			j	Sugar or Albumin in urine			q	Admission Two years				Tuberculosis
d	Hay fever			k	Epilepsy or fits			r	Rejection for life insure			x	Are you in good physical and mental health as far as you know and believe
e	Asthma			l	Nervous Trouble of any kind			s	Aviation accidents				

f	Heart trouble			m	Any drug Narcotic								
g	High or low blood pressure			n	Excessive Drinking habit			u	Gynecology/Obstetrical Conditions				
REMARKS													

(For Girls)has this person menstruated? ---------- If so , Is her

Menstrual history normal? ---------- special considerations: ----------

Immunization record

MMR: ----------

DPT :----------

POLIO; ----------

TB TESTING:----------

HEPATITIS B:----------

Not by physician the above named child request to sports program conducted by the college

We would appreciate any information of the child that may be able share with u ----------
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Strenuous activity Restrictions

_____
_____

Medications prescribed by you or any other physician known to you ----------
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1. Any history of late or typical maturation of the central nervous system?
2. Any family of seizure disorders, heat disorders or psychological issues Requiring hospitalization, frequent or occasional or lon-term.
3. Please comment on any chronic or recurrent illness (eg. Asthma)

I have examine the person described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in college sponsored strenuous activities, except noted.

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Examining Physician's Signature Please print Physician's Name

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Address Phone

Date of examination: ----------

When you completed this form, please forward to:

The Chief Executive Officer

United Tanzania Aeronautic College

P.O. Box 62080

Dar Es Salaam

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