DARDA HEALTH PRE-UNIVERSITY

LOCAL STUDENTS APPLICATION FORM (LOSAF)

Fix passport picture Here

PHOTO

2019 – 2020 ACADEMIC YEARS ONLY

APPLICANTS SHOULD READ THE GUIDELINES BELOW CAREFULLY BEFORE APPLYING

Please attach the following to LOSAF:

i. Certified Photocopy of Result slips.
ii. TWO recent white background passport-size photographs one of which should be fixed on the form.
The remaining photograph should be endorsed (See Declaration on back page)

(Upon Complete filling of forms: Send Hard Copy of filled forms using express post (EMS) to: DARDA HEALTH PRE-UNIVERSITY, P.O. Box WU 194, KASOA-C/R)

The application fee for this form is One Hundred Ghana Cedis (GHS 100) and can be paid for by selecting any one of the following payment options:
1. Send us an MTN mobile money payment using our number: **0558767002.**
2. Pay directly or wire transfer into the local account of Darda Health Pre-University:
Bank Name: ECOBANK Ghana Limited, Weija Branch (Ghana Cedis only)
Account Name: Darda Health Pre-University
Account Number: 0330264494753501.
Swift Code: ECOCGHAC

NB: Your admission letter would only be processed upon confirmation of payment of this form.

Please fill LOSAF in BLOCK LETTERS (WhatsApp or Call hotline for clarity: 0261803751)

1. Name

TITLE: MR/MRS/MISS

SURNAME

OTHER NAME

(Ensure that names correspond with those used for all examinations taken. Provide legal proof for any change in name)

2. Date of Birth (day, month, year)

d	d	m	m	y	y	y	y

3. Sex M/F

4. Address to which communication regarding this application should be sent

……..

……..

E-mail Address……..Tel. No(s)……

5 i. Place of Birth……

ii. Nationality……..

iii. Home Town……..

iv. Region and Country……..

v. Religion……

6. Do you suffer from any form of impairment? Yes No (circle)

7. If Yes, specify ……..

Name of Parent or Guardian ……..

Relationship to Candidate……..

Address of Parent or Guardian……..

Tel: ……...E-mail……

Occupation of Parent or Guardian ……

Date…… Signature of Applicant …….

8. EDUCATION

Secondary Schools and Colleges attended with date

Name of Secondary School/College	Attended Dates From-To	Offices Held

Examination details:

Attempts	Ist	2nd	3rd
Name of Exam			
Year			
Index No(s)			

Indicate Grades obtained

SUBJECTS	GRADES (eg. A1, B2, C6, etc)		
	1st Attempt	2nd Attempt	3rd Attempt
Social Studies			
English Language			
Core Mathematics			
Integrated Science			
ELECTIVES YOU PURSUED			
1.			
2.			
3.			
4.			

PROGRAMME YOU APPLYING for: TICK

☐ **PRE-NURSING / PRE-MIDWIFERY (***Students of All background can apply***)**

☐ **PRE-MEDICINE / PRE-PHARMACY (***Students must be prepared to read pure science***)**

☐ **DIPLOMA IN BUSINESS ADMINISTRATION (Accounting, HR, Marketing,…)**

☐ **DIPLOMA IN INFORMATION TECHNOLOGY (Computer Science)**

☐ **PROFESSIONAL COURSE (Corel Draw, Web Designing, MCSE)**

OTHER:…… (eg. CA, ACCA)

REMINDER: *YOU MUST SEND THE COMPLETED HARD COPY OF THIS FORM BY POST. FORMS SENT WITHOUT PROOF OF PAYMENT WOULD NOT BE PROCESSED.*

DECLARATION BY WITINESS

The declaration should be signed by someone of high repute who should also endorse one of the passport-size photographs on the reverse side. This person should be a Senior Public Servant/Clergyman/Lawyer/Medical Practitioner. The application will not be valid if this is not signed.

I certify that the photograph endorsed by me is the true likeness of the applicant …….who is personally known to me. I have inspected his/her certificates and I am satisfied that the names on them conform to those by which, to the best of my knowledge, he/she is officially known.

Name of Witness:……..
Status or Profession:…….
Address:……
Date:……
Signature AND Stamp:……..

DARDA HEALTH PRE-UNIVERSITY

MEDICAL REPORT FORM

To be completed by a recognized Medical Practitioner and returned to the Administrator at Darda Health Pre-University P.O. Box WU 194 Kasoa, Ghana.

NAME OF STUDENT:.....

STUDENT ID / APPLICATION FORM No.:.....

DATE:.....

This is to certify that I have examined Mr./Mrs./Miss…….and

have to report as follows:

BLOOD GROUP :……

SKIN SNIP :……...

PULSE RATE :……..……

B/F :…….

HEART :……..

LUNGS :……..…

X-RAY :……..

ABDOMEN :……..……..

C.S.M :……...

E.N.T. :……..

EYE-LEFT :……..……..

EYE-RIGHT :……..……..

VACCINATION :……..……

I therefore declare him/her **fit/unfit**

……. ……..

DATE

MEDICAL OFFICER
(Stamp and Signature)