"FORM 8A"

ALLIED HEALTH PROFESSIONALS ACT, CAP. 296
APPLICATION FOR REGISTRATION OF A PRIVATE ALLIED HEALTH UNIT

1. Professional's Name:……...……
2. Registered title of the Applicant:…….……...…..
3. Registered Number:…….……...……..
4. Registration Date:…….…...…….
5. Name of health unit:…….…….
6. Postal Address:……Tel. :……...……..…….
7. Town: ……Plot No./Locality:…….…….
8. Sub county/Street:……..City/Town/Town Council:…..……
9. District:……..…….
10. Category of Allied Health Unit (Tick)
    a) Medical Clinic
    b) Dental Clinic/Lab
    c) Ultra Sound Unit
    d) Physiotherapy Unit
    e) Orthopedic Clinic
    f) Ophthalmic/eye Clinic
    g) Psychiatric Clinic
    h) Drug Shop
    (i) Orthopedic Rehabilitation centers
    (j) Vector control centers

11. Has any of your application ever been rejected? Yes☐ No☐

If yes, why……

……..

Signature: ……..

Note: Please attach

- Fully filled and stamped checklist from District Health Inspector
- Copy of Registration Certificate for the Professional
- Copy of current Annual Practicing License
- Copy of Academic Transcript(s)/Certificate(s)
- Copy of current Extract from the register

FOR OFFICIAL USE ONLY

Recommendation from Registrar:…….....

……..

Signature:…….. Date:……...……