



## **MWANZA COLLEGE OF HEALTH AND ALLIED SCIENCES (MWACHAS) SCHOOL OF ANESTHESIA**

### **APPLICATION FOR ONE YEAR CERTIFICATE COURSE IN ANESTHESIA**

**ACADEMIC YEAR MARCH 2026 / FEBRUARY 2027.**

We are happy to invite applications to study Anesthesia at MWACHAS-Bugando school of Anesthesia. Please fill in the spaces provided in the forms and submit your application to Bugando school of Anesthesia using either of the options below. The application is open from 25<sup>th</sup> NOVEMBER 2025 and the **deadline** for application is FEBRUARY 28<sup>th</sup> 2026.

#### **PART ONE: DETAILS OF APPLICATION**

##### **REQUIREMENTS / ELIGIBILITY:**

- (a) Applicant must be a nurse or clinical officer. We do not receive applicants fresh from secondary school or professions other than the two mentioned above.
- (b) Applicant must attach all verified copies of secondary education and professional training-nursing or clinical medicine.
- (c) Applicant must attach a Medical Certificate stating the fitness of the applicant.
- (d) Photocopies of the applicant's relevant certificates including Internship certificate and registration certificate with Medical Council of Tanganyika.
- (e) Two (2) recent passport-size photos of the applicant with blue background.
- (f) A recommendation letter from the applicant's employer is an added advantage
- (g) For FOREIGNER NURSES, you must be cleared by Tanzania Nursing and Midwifery Council

##### **APPLICATION PROCESS:**

Can be done through any of the following:

- Application form well filled in and returned personally OR;
- Delivered by post mail: address

**HEAD,**

**MWACHAS-BUGANDO SCHOOL OF ANESTHESIA**

**P.O BOX 1370,**

**MWANZA.**

OR;

- By email: [school.anaesthesia@bmc.go.tz](mailto:school.anaesthesia@bmc.go.tz) OR [rebbyshejiy@gmail.com](mailto:rebbyshejiy@gmail.com)

**When applying please indicate your correct email address and current phone number.**

**APPLICATION FEE:**

Application fee of Tsh.25,000/= (Non-refundable) should be paid through the following bank account:

**BMC VYUO COST SHARING**

**CRDB BANK**

**ACCOUNT NUMBER 01J1054747600.**

Applicants who do not pay application fee will not be considered for selection!

The original copy of the payment receipt for the application fee should be attached

**PART TWO: OTHER DETAILS:**

**1. FEES, RESIDENCE AND OTHER EXPENSES**

FEE STRUCTURE ONE YEAR TRAINING IN ANESTHESIA 2025-2026.

FEE STRUCTURE S#	PAYMENT/ITEM	PAYABLE TO	AMOUNT
1	STUDENT ID	TO THE COLLEGE	20,000/=
2	CASE LOG BOOK	TO THE COLLEGE	20,000/=
3	TUITION FEE	TO THE COLLEGE	1,100,000/=
4	CAUTION MONEY	TO THE COLLEGE	50,000/=
5	EXAMINATION FEE	TO THE COLLEGE	150,000/=
6	FIELD SUPERVISION	TO THE COLLEGE	150,000/=
7	CERTIFICATE	TO THE COLLEGE	20,000/=
8	STUDENT UNION & SPORTS	TO THE COLLEGE	15,000/=
TOTAL			1,525,000/=
TOTAL COST OF FOR ONE STUDENT PER YEAR			1,525,000/=

**STUDENT EXPENSES (NOT PAYABLE TO THE COLLEGE)**

S/N	PAYMENT/ITEM	PAYABLE TO	AMOUNT
1	STIPEND	STUDENT	3,600,000/=
2	ACCOMMODATION	STUDENT	600,000/=
3	BOOKS ALLOWANCE	STUDENT	200,000/=
4	FIELD ALLOWANCE	STUDENT	150,000/=
5	MEDICAL INSURANCE	STUDENT	50,400/=
TOTAL			4,600,400/=
TOTAL COST OF FOR ONE STUDENT PER YEAR			4,600,400/=

Money directly payable to the college should be paid through:

**BMC VYUO COST SHARING  
CRDB BANK  
A/C NUMBER 01J1054747600**

2. PERSONAL DETAILS:

Your name: [FIRST  
[NAME]\_\_\_\_\_[MIDDLENAME]\_\_\_\_\_[SURNAME]\_\_\_\_\_  
\_\_\_\_\_  
[GENDER].....Male/Female[M/F]  
ADDRESS\_\_\_\_\_CITY\_\_\_\_\_  
Mobile phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Work station: \_\_\_\_\_(hospital)  
Date of birth: [DD/MM/YY] \_\_\_\_/\_\_\_\_/\_\_\_\_Place of birth \_\_\_\_\_  
Nationality\_\_\_\_\_ Passport #: \_\_\_\_\_

For Emergencies:

NAME: \_\_\_\_\_  
\_\_\_\_\_  
RELATIONSHIP\_\_\_\_\_  
ADDRESS\_\_\_\_\_CITY\_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_

3. ACADEMIC DATA

ALL SEC.SCHOOOLS ATTENDED	LOCATION	DATE: FROM (MONTH/YR)	TO (MONTH AND YEAR	CERTIF.INDEX NO
ALL COLLEGES/SCHOO LS	LOCATION	DATES: FROM	TO	DIPL/CERT.EARN ED

Total number of years of schooling: \_\_\_\_\_years and \_\_\_\_\_months [From  
secondary school].

4. LANGUAGE FLUENCY [Please put a tick for each language]

LANGUAGE	SPOKEN			WRITTEN		
	FAIR	GOOD	VERY GOOD	FAIR	GOOD	VERY GOOD

5. REFEREES

Names and addresses (email and phone numbers) of two referees who know your ability as a  
student and can assess your competence in written and spoken English.

a) \_\_\_\_\_Email: \_\_\_\_\_  
Phone: \_\_\_\_\_  
b) \_\_\_\_\_Email: \_\_\_\_\_  
Phone: \_\_\_\_\_

6. SIGNATURE AND DATE

I certify that to the best of my knowledge the information I have given above is correct.  
(Date) ..... (Signed) .....

**7. SPONSORSHIP.**

The Sponsor should indicate here that the candidate will receive financial support for the year the applicant will spend at MWACHAS college.

NAME OF SPONSOR \_\_\_\_\_

P.O. BOX CITY OR TOWN \_\_\_\_\_ TEL/MOBILE: \_\_\_\_\_

BUSINESS OR ACTIVITY \_\_\_\_\_

FAX/E-MAIL \_\_\_\_\_

I myself,

I confirm that my organization will give full financial support to \_\_\_\_\_ during the period of his/her education at Bugando school of Anesthesia, if he/she is accepted.

(date) \_\_\_\_\_ (Signed) \_\_\_\_\_

Official stamp or seal

FOR OFFICIAL USE ONLY

**PLEASE ENCLOSE PHOTOCOPIES OF ALL TRANSCRIPTS**

*YOU ARE MOST WELCOME.*

**By: HEAD BUGANDO SCHOOL OF ANESTHESIA (+255757754013)**

MEDICAL CERTIFICATE

SURNAME..... OTHER NAMES.....

AGE..... SEX .....

MARITAL STATUS .....CITIZENSHIP.....

PERSONAL HISTORY

Is the examinee suffering from any of the following? Indicate Yes or No.

Dysentery..... Kidney or urinary disease.....

Epilepsy..... Psychosis .....

Pneumonia ..... Sickle cell disease.....

Allergic disorder.....(mention allergen).....

Gastric or duodenal Ulcer.....Jaundice .....

Varicose Veins ..... Diabetes .....

Deformity..... Eye disorder .....

Skin disease ..... Gynecological disorder .....

Major trauma ..... Tuberculosis .....

Pleurisy ..... Rheumatic Fever.....

Heart Disease ..... Recurrent indigestion .....

Ear , Nose or Throat disorder ..... Chronic Anemia .....

Malaria..... Major or minor operations .....

Any other serious disorder ..... History of TB contact.....

PHYSICAL EXAMINATION

Height:.....cm Weight: .....kg. HEENT:.....

Ears(Any discharge):.....Nose:.....

Cardiovascular: BP.....mmHg HR.....Regular Any

murmurs:.....

Respiratory: Wheezing:.....Breath sounds:.....RR.....

Abdomen:.....Hernia:.....Masses.....Liver.....

.....Kidneys.....Spleen.....

LABORATORY RESULTS

Urinalysis: Sugar.....Bilharzia.....Albumin.....

Stool: Worms.....

Blood:Blood Group:.....FBP-Hb.....g/dL

Neutrophils.....Eusinophils.....Bisophils.....Lympho  
cytes.....

Monocytes.....ESR.....Platelets.....

Chest Xray:(If Indicated).....ECG.....

ECHO.....

CONCLUSION

I have examined Mr/Mrs/Miss/Sr/Br/Fr/Dr.....and considered that she/he is /  
not physically and mentally fit to be admitted for further studies.

Name..... Signature..... Date .....

Title .....Qualifications .....

Address/Institution Official stamp [of hospital].....