Creating Awareness For Responsible And Informed Choices

APPLICATION FOR CLINICAL ATTACHMENT

Please complete this application form and submit with supporting documents to:

P.O Box 31502- 00600, Nairobi.
Email: info@cafric.org

DETAILS OF REQUESTED CLINICAL ATTACHMENT		
Period of Clinical Attachment:		
Have you been in contact with any staff member from CAfRIC Centre?		
PERSONAL DETAILS		
Full Names:		
Passport/ ID No:	Date of Birth:	Nationality:
Address:	Email Address:	
	Phone:	
EDUCATION		
School Attended:	Year of Study:	
Course:		

GUIDELINES FOR ATTACHMENT STUDENTS

i. About the programme

1. The period of attachment is up to a maximum of 3 months, unless otherwise specified.
2. Attachment is subject to the Clinical Director's approval.
3. This is a voluntary programme and there will be no remuneration paid for the duration of attachment.

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ii. Guidelines for Attachees

All attachees on Clinical Attachment must adhere to the following:

1. All attachees **MUST** backup their application for Clinical Attachment with an official recommendation letter from their respective schools.
2. Attachees **MUST** have valid medical health insurance coverage (NHIF or equivalent).
3. All attachees will be under supervision for any and all duties and responsibilities assigned throughout the attachment period.
4. All persons on attachment **MUST** maintain full confidentiality regarding clients at CAfRIC Centre.
5. Attachees **MUST** observe official and decent form of dressing.
6. Any confidential information which may have been acquired during the course of attachment shall not, during or after termination of attachment, be used or disclosed to any third party.

DECLARATION

I declare that the particulars in this application are true to the best of my knowledge and belief, and I have not willfully suppressed any material facts. Any misinterpretation or omission of information will be grounds for withdrawal of acceptance for the clinical attachment. I have also read and understood the guidelines stated herein.

_____ _____

Signature of Applicant **Date**

FOR OFFICIAL USE ONLY

Application approved/ Disapproved:

_____ _____

Clinical Director's Signature **Date**