



# THE INFECTIOUS DISEASES INSTITUTE

Faculty of Medicine  
Makerere University  
Kampala Uganda



## - IDI Training Program - Application Form

Section A: Personal Profile			
Surname	First Name	Gender: Female: <input type="checkbox"/> Male: <input type="checkbox"/>	Date of Birth: _/_/____ D M Y
Address (or P.O Box)		City (w/ postal code if applicable)	Country
District (Uganda Residents Only)		Nationality	Country of Residence
E-mail Address:		Phone # (include country code)	Fax# (include country code)
Profession ( <i>Tick all applicable options</i> ): <input type="checkbox"/> Specialist _____ <i>Specify</i> <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Clinical Officer <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Registered Midwife <input type="checkbox"/> Enrolled Nurse M/W <input type="checkbox"/> Laboratory Technologist <input type="checkbox"/> Laboratory Technician <input type="checkbox"/> Laboratory Assistant <input type="checkbox"/> Pharmacist <input type="checkbox"/> Dispenser <input type="checkbox"/> Counselor <input type="checkbox"/> Social Worker <input type="checkbox"/> Allied Health Worker _____ <i>Specify</i>		Military Service Member? Yes: <input type="checkbox"/> No: <input type="checkbox"/> <i>(If yes, please indicate nation, branch, and rank)</i>	
Course applying for: <input type="checkbox"/> HIV _____ <i>specify</i> <input type="checkbox"/> Malaria _____ <i>specify</i> <input type="checkbox"/> Laboratory _____ <i>specify</i>		Preferred Date of training: _/_/____	
Employer Name & Address:		Employer agency type: <input type="checkbox"/> Government Agency <input type="checkbox"/> Military <input type="checkbox"/> Non governmental Org (NGO) <input type="checkbox"/> Faith Based Org <input type="checkbox"/> Private <input type="checkbox"/> Other _____ <i>specify</i>	

Workplace Address: If different from employer	Place of Work: <input type="checkbox"/> Teaching Hospital <input type="checkbox"/> Government Agency <input type="checkbox"/> Regional/District Hospital <input type="checkbox"/> Health centre IV (Major health centre) <input type="checkbox"/> Dispensary or Health Centre I-III <input type="checkbox"/> Community based health services <input type="checkbox"/> Private for profit
Do you have a sponsor for the training? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Sponsor agency type: <input type="checkbox"/> Government Agency <input type="checkbox"/> Military <input type="checkbox"/> Non governmental Org (NGO) <input type="checkbox"/> Faith Based Org <input type="checkbox"/> Private <input type="checkbox"/> Other _____ <i>specify</i>
If yes, Name Address & Phone # of sponsor	

### Section B: Educational Profile

Educational Institution	Qualification	Degree/Qualification	Year Awarded
		<input type="checkbox"/> PhD <input type="checkbox"/> Msc <input type="checkbox"/> Bsc <input type="checkbox"/> Higher Diploma <input type="checkbox"/> OrdinaryDiploma <input type="checkbox"/> Certificate <input type="checkbox"/> Other _____ <i>(specify)</i>	
		<input type="checkbox"/> PhD <input type="checkbox"/> Msc <input type="checkbox"/> Bsc <input type="checkbox"/> Higher Diploma <input type="checkbox"/> OrdinaryDiploma <input type="checkbox"/> Certificate <input type="checkbox"/> Other _____ <i>(specify)</i>	
		<input type="checkbox"/> PhD <input type="checkbox"/> Msc <input type="checkbox"/> Bsc <input type="checkbox"/> Higher Diploma <input type="checkbox"/> OrdinaryDiploma <input type="checkbox"/> Certificate <input type="checkbox"/> Other _____ <i>(specify)</i>	

### Section C: Previous Training

HIV/TB	Date	Malaria	Date	Laboratory	Date
Management of HIV programs		Management of complicated malaria		HIV Counseling and Testing	
HIV prevention		Management of uncomplicated malaria		Laboratory Techniques in HIV/AIDS	
HIV testing and counseling		Management of malaria in pregnancy		QA and QC in Laboratory Services	
HIV care		Malaria diagnostics		Good Laboratory Practice	
Community based HIV care				Training of Trainers	
ARV in HIV management				Clinical Laboratory Management	

PMTCT				Monitoring & Evaluation	
HIV logistics management				Others (specify)	
Palliative care					
Training of trainers					
Research					

Section D: Employment History			
Employer	Location	Employment Dates	Position held
		Start ___/___/___ M Y End ___/___/___ M Y	
		Start ___/___/___ M Y End ___/___/___ M Y	
		Start ___/___/___ M Y End ___/___/___ M Y	

Section E: Interests (After completion of this training, what area of practice do you plan to be involved in?)		
HIV/TB	Malaria	Laboratory
Management of HIV programs	Management of complicated malaria	HIV Counseling and Testing
HIV prevention	Management of uncomplicated malaria	Laboratory Techniques in HIV/AIDS
HIV testing and counseling	Management of malaria in pregnancy	QA and QC in Laboratory Services
HIV care	Malaria diagnostics	Good Laboratory Practice
Community based HIV care		Training of Trainers
ARV in HIV management		Clinical Laboratory Management
PMTCT		Monitoring & Evaluation
HIV logistics management		Others (specify)
Palliative care		
Training of trainers		
Research		

Are you involved in the training of other health care workers? Yes:  No:   
 If yes please describe training activities you are engaged in:

Are you involved in Continuing Professional Education? Yes:  No:   
 If yes please describe training activities you are engaged in:

Are you involved in the management of a programme? Yes:  No:   
 If yes, outline your responsibilities:

After completion of this training, what area of professional services do you plan to improve?

<b>Section E: Information Technology Survey</b>					
Do you own or have access to a computer? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		Do you have access to the Internet? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		Have you received formal Computer training? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Please rate your skill with the following software applications:					
Application	Beginner	Intermediate	Advanced	Need Training	
Microsoft Word					
Microsoft Excel					
Microsoft Access					
MS PowerPoint					
Epi-Info					
Other Email package: specify					
Microsoft Explorer (web browser)					
Other web browser Specify					
Other data base Specify					
Search Engines (Google, Yahoo etc)					
Professional Search engines (NLIM Pub Med etc) specify					

What are your objectives for applying for this course?

Have you ever applied for a course at IDI? Yes:  No:

If yes, what course(s) did you apply for: \_\_\_\_\_  
(Include dates)

If yes, what is your IDI application/ Student Number? \_\_\_\_\_

I \_\_\_\_\_ (Full Name) hereby certify that the above information is true and constitutes a valid description of my experience and qualifications

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

Applicants must submit the following documents:

- the completed application form clearly indicating
  - o which course you would like to take
  - o the course dates
- an up to date current curriculum vitae
- a formal letter of recommendation from the employing institution (e.g. hospital administrator, clinical director, department chair) indicating the your role in patient care and/or training of other health care providers as well as expected benefits of the training to the institution.

**For more information and submission of applications please contact:**

**Training Department**  
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