INSTITUTE OF HEALTH CARE MANAGEMENT, NIGERIA

Registration form for Post Graduate& Higher Diploma

Name: Mr/Mrs/Miss_____
Surname Other names

Registration No: _____

Sex:_____ Date of Birth: _____

Home Address: _____

_____

Address During Session: _____

_____

State of Origin/Nationality: _____

Date of Session: _____

Name of Sponsor: _____

Address of Sponsor: _____

Qualification Obtained: _____

Professional Qualification(s) (where applicable)_____

Status of Registration: _____

Awarded Degree Institution/Professional Body

_____ Date of Award _____

Programme Currently Registered for _____

Mode of Study: _____ Course: _____

Specialisation: _____ Duration: _____

_____ _____
Signature of Student/Date Signature of Coordinator/Date