



OPTIMA COLLEGE

CONTACT CENTRE SUPPORT

APPLICATION FORM

LEARNING PROGRAMME APPLIED FOR:

A: SKILLS PROGRAMME (2 MONTHS) OR

B: LEARNERSHIP PROGRAMME (12 MONTHS)

PLEASE NOTE:

Incomplete applications will not be considered.

Please ensure that the following are attached:

- Medical Report**
- Ophthalmologist/Optomtrist/Low Vision Clinic Report (if you are first time applicant to Optima College Ophthalmologist/Optomtrist/Low vision is compulsory)**
- Certified copy of Identity Document**
- Certify copy of Computer Certificate**
- Certified copy of high school qualification**

1. PERSONAL INFORMATION

1.1 Title: (Mr/Mrs/Miss, etc).....

1.2 Surname:

1.3 Full Names:

1.4 Physical Address:.....

..... Province:.....

- 1.5 Postal Address:
 Postal code:.....
- 1.6 Gender: Male / Female
- 1.7 Marital Status:.....
- 1.8 Nationality:
- 1.9 Age: Date of Birth:
- 1.10 Identity Number:.....
- 1.11 Home Language:
- 1.12 Do you require Hostel Accommodation Yes No If yes, please complete Hostel Accommodation attached.
- 1.13 Name of next of kin:
- 1.14 Relationship:
- 1.15 Address:

- 1.16 Telephone and Code: (Home)
 (Work).....
 (Cell)

2. LANGUAGE OF INSTRUCTION

NB: PLEASE NOTE THAT ENGLISH IS THE MEDIUM OF INSTRUCTION FOR ALL LEARNING PROGRAMMES.

	PROFICIENCY in English (indicate below whether Good/Fair/Limited)
Speak	
Read	
Write	

3. FEES AND DECLARATION

* Tuition (training): payable per module in full.

Name and Address of Person Responsible for Fees:

.....
 Telephone: Fax: Code:

4. MEDICAL REPORT

This form must be completed in BLOCK LETTERS by a medical practitioner

4.1 Name of patient:

4.2 Address:

4.3 What is the patient's general condition of health?
 Furnish particulars of any illness or ailment the patient may be suffering from:

.....

4.4

Does the patient display signs of:	YES	NO	IF YES, GIVE DETAILS
Skin diseases			
Ailments of the joints			
Disorders of ears and nose			
Cardiovascular condition			
Respiratory condition			
Neurological disorders			IF YES ATTACH NEUROLOGY REPORT
Psychological conditions			
Physical disability			
Epilepsy			
Diabetes			
Loss of hearing			
Speech Impairment			
Any other condition that you consider relevant (please specify)			

5.5 Give details of prescribed treatment/medication:

.....

5.6 Name of Doctor:

Address/ Telephone:.....

Doctor's Signature: Date:.....

5. DIABETES REPORT

This form must be completed in BLOCK LETTERS, by a medical practitioner, **if the patient has a history of diabetes.**

- 5.1 Name of patient:
- 5.2 Condition since (date):
- 5.3 How is the diabetes being controlled :(Specify):
 - a) Diet:.....NB: Please include a written recommended diet with the report
 - b) Medication: (specify).....
 - c) Insulin :(specify).....
 - d) Other:
 - e) If uncontrolled; explain:
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- 5.4 When last did the patient suffer from insulin shock?
- 5.5 If any, what symptoms does the patient display?
- 5.6 If any, specify complications in respect of:
 - a) Kidneys/other organs:
 - b) Nervous System:
 - c) Can the patient draw and inject him/herself with insulin?
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- 5.7 Is his/her daily insulin dosage constant?
- 5.8 Can the patient monitor his/her own blood sugar?
- 5.9 Further relevant information, if applicable
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- 5.10 Name of Doctor:
- Address/Telephone:
- Doctor's Signature: Date:.....

6. OPHTHALMOLOGICAL REPORT

This form must be completed in BLOCK LETTERS by an Ophthalmologist/Optomestrist/Low Vision clinic.

Name of patient:

Address:

Diagnosis: Prognosis.....

Is the patient Totally Blind or partially sighted?.....

Date of onset of Blindness:

If hereditary; please elaborate:.....

.....

Remaining vision:

VISUAL ACUITY:

Without Correction

With Correction

Right Eye:.....

Right Eye:

Left Eye:

Left Eye:

VISUAL FIELD:

Left eye:

Right Eye:

Photophobia:

Colour Blindness:

Night Blindness:

Is the patient taking eye medication? (If yes please specify.....

Has the patient ever had a Low Vision Examination?.....

If yes, by who and when?

Does the patient use any Low Vision Devices?

Further Comments/ Recommendations?

.....

Name of Ophthalmologist/Optometrlist/ Low vision Clinic:

Address:.....

.....Tel number:.....

SIGNATURE:..... Date:

DECLARATION

I.....(name & surname) understand and agree.

Applicant signature:

Date: