APPLICATION FORM

Complete in full (block letters) and return with your deposit, a certified copy of your ID or Passport and Certificates (e.g. MSCE)

Course Name/Code:_____[Please indicate course name or code i.e **ECD01CTC**]

Course Duration: 6 months [Saturday afternoons 08:00am to 16:00pm]* **Starting Date:**_____/_____/ 20_____

Learner Information:

Surname (as on ID Document):_____Known name: _____

Names:_____Race:_____

Health Problems:_____Medical Aid: Yes ☐ No: ☐

ID Number or Passport Number:

Address: _____

_____Postal Code: _____

Postal Address:_____Postal Code: _____

Telephone Number (Home):_____(Work):_____(Cell Phone):_____

E mail Address: _____

Highest Qualification: _____

Name of Educational Institution: _____

Emergency Contact Details (Next of Kin):

Surname:_____Name: _____

Telephone Number (Home):_____(Work):_____(Cell Phone) _____

Payment Agreement:

Cash Price: MWK _____

Deposit Fee: MWK _____

Learner Agreement:

I acknowledge that I shall not be entitled to any reduction or refund for fees should I not complete the training for any reason whatsoever.

If accounts are not paid as per conditions stated on invoice, I / we will be handed over for collection to a debt collection agency, I shall be liable for all costs incurred on a scale as between attorney and own client.

*I agree that I will NOT permit anyone to study from or use any course material I receive without the written permission of the **Childcare Training College.***

Learner Signature:_____Date: _____

Full details of person or business responsible for fees – ONLY IF NOT THE LEARNER.
If responsible person or business to be invoiced instead of Learner – please tick:

YES	NO
☐	☐

Business or Person Name (Responsible for fees): _____

Contact Person: Surname:_____**Name:** _____

ID or Passport Number:
Company Registration:

Address:_____Postal Code: _____

Postal Address:_____Postal Code: _____

Telephone Number (Home)_____(Work):_____(Cell Phone): _____

Email Address: _____

Signature:_____Date: _____