AFRICA CENTRE OF EXCELLENCE
CENTRE FOR PUBLIC HEALTH AND TOXICOLOGICAL RESEARCH
UNIVERSITY OF PORT HARCOURT

ACE PUTOR UNIPORT

REGISTRATION NUMBER: ______________________________

PASSPORT PHOTO

REGISTRATION FORM

1. SURNAME (BLOCK CAPITAL):
2. OTHER NAMES
3. FORMER NAME (IF APPLICABLE, EVIDENCE SHOULD BE ATTACHED):
4. DATE OF BIRTH:
5. PLACE OF BIRTH:
6. MARITAL STATUS:
7. NATIONALITY:
8. STATE OF ORIGIN:
9. PRESENT EMPLOYMENT:
10. PRESENT ADDRESS:
11. TEL. NO:
12. EMAIL ADDRESS:
13. CONTACT DETAILS OF NEXT OF KIN: Name: ________________________________
    Address: ____
    Email: ______________________ Phone: ________________________________
14. CONTACT DETAILS OF PHYSICIAN: Name: ________________________________
    Address: ____
    Email: ______________________ Phone: ________________________________
15. HISTORY OF (a) Disability Yes ☐ No ☐ (b) Allergen Yes ☐ No ☐ (c) Chronic Illness Yes ☐ No ☐

16. Educational Institutions Attended, Academic Qualifications with Dates:

INSTITUTION	**QUALIFICATION**	**START DATE**	**COMPLETION DATE**	**GRADE & CGPA**

17. Current Status: ☐ Student ☐ Employed ☐ Others (please give details)

18. Sources of Funding: ☐ Personal ☐ Government ☐ Organisation ☐ None

19. Employment History

Year	Company	Position Held	Job Description

20. Prizes/Awards

Year	Prize/Award	Awarded by

21. Language Proficiency (insert A for excellent, B for good, C for average and D for poor)

Language	Spoken	Read	Written	Diploma/score/date
English				
French				
Others(s)				

22. Degree enrolled into:

23. Area of Specialization (if applicable):

24. Major Research Interest:

25. Study option: ☐ Full time ☐ Part-time

26. Current place of work (for part-time student):

27. Position……………………………………… Duration ……………………………………………..

28. Names, Addresses and Emails of three (3) Referees:

S/N	Name	Address	Email	Phone
1				
2				
3				

29. Declaration of Applicant

I hereby declare that the information supplied are true to the best of my knowledge and belief. I am aware that withholding or giving false information if discovered will prevent me from continuing my study. I promise to abide by the rules and regulations of the Centre and that of the University of Port Harcourt.

Signature____________________ Date____________________

OFFICE USE

PAYMENT DETAILS					
PURPOSE	**AMOUNT**	**BANK**	**TELLER NO**	**DATE**	**ACCT SIGN**

ELECTIVES REQUIRED

COURSE TITLE	COURSE CODE	COURSE TITLE	COURSE CODE

Health record: ____

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Other recommendations: ____

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Email: aceputor@uniport.edu.ng **Phone:** +234(0)8136592033; +234(0)8129429447