(FORMERLY, KENYA WILDLIFE SERVICE TRAINING INSTITUTE)

APPLICATION FORM

COURSES COMMENCING MAY/ SEPTEMBER 2025

Affix applicants' two (2) passport size photos on a white background

INSTRUCTIONS

1. This application must be completed and accompanied by certified photocopies of certificates or academic transcripts/results slips written in English. Where financial support is from a donor, written confirmation from the donor is required.
2. Applicants should be proficient in written and spoken English.
3. This form should be completed using BLOCK LETTERS.

Completed Application Forms must be accompanied by a non-refundable application fee through a bank deposit slip of KES 2,000 for East Africans and US$40 for non-East Africans payable to **Wildlife Research & Training Institute,** KCB Naivasha, Account No.**1286224489**. All applications must be sent to:

The Director
Wildlife Research & Training Institute
P. O. Box 842-20117
NAIVASHA
Mobile: 0700 000 321 or 0797 900 800 or 0792 280 000
E-mail: *training@wrti.go.ke*

PART A: PERSONAL DETAILS (Part A to E to be filled by the applicant)

1. NAME (Surname or Family Name): _____ (Other Names): _____
2. DATE OF BIRTH: _____ GENDER: _____
3. NATIONALITY: _____ ID/PASSPORT NO. (If applicable): _____
4. MAILING/POSTAL ADDRESS: _____

TEL. No: _____ E-mail: _____

PART B: COURSE FOR WHICH ADMISSION IS BEING SOUGHT (tick one only)

#	COURSE AND DURATION	MINIMUM ENTRY GRADE	CHOICE (Tick One)
1	Diploma in Environmental Management (18 Months)	C-	
2	Diploma in Fisheries and Aquatic Sciences (18 Months)	C-	
3	Diploma in Tourism & Hospitality Management (18 Months)	C-	
4	Diploma in Wildlife Management (18 Months)	C-	
5.	Certificate in Aquaculture (9 Months)	D	
6.	Certificate in Community Wildlife Management (9 Months)	D	
7.	Certificate in Nature Interpretation & Tour Administration (9 Months)	D	
	TICK THE INTAKE YOU WISH TO JOIN: ☐ APRIL ☐ SEPTEMBER		

PART C: ACADEMIC QUALIFICATIONS

(Provide details of schools/colleges attended, dates and qualifications attained starting with the most recent)

DATE	INSTITUTION	QUALIFICATION AND GRADE

PART D: PROFESSIONAL EXPERIENCE (if applicable)

(Provide details of your employment and professional experience giving dates, organization and positions served in starting with the most recent)

DATE	EMPLOYER/ORGANISATION	POSITION

PART E: DECLARATION

I _____ (Name) certify that the above information given by me is correct and I wish to apply for admission as a student at the WILDLIFE RESEARCH AND TRAINING INSTITUTE, NAIVASHA, KENYA.

(Signature): _____ (Date): _____

PART F: RECOMMENDATION AND FINANCIAL SUPPORT

(To be filled by the employer, sponsor/guardian)

(Name of employer or sponsor/guardian) _____ hereby approves and recommends the candidate named in PART A of this application for the course applied for. FINANCIAL support for the training will be met by:

(Name and address of employer or sponsor/Guardian)

NAME:_____ DESIGNATION:_____

RELATIONSHIP TO APPLICANT_____

ADDRESS: _____ TELEPHONE NO: _____

SIGNATURE: _____ DATE: _____

SPONSOR'S OFFICIAL STAMP (where applicable)

PART G: FOR OFFICIAL USE

(i) Application Accepted (ii) Application Rejected (tick appropriately)

Reason for rejection (Incomplete application; does not qualify; late application) (tick appropriately)

Admission letter Issued on: _____ **Deputy Director Training** Signature: _____

MEDICAL EXAMINATION FORM (2025)

NOTE: The applicant once enrolled is likely to undergo prolonged physical exertion in extreme conditions at remote areas. The applicant therefore MUST be physically fit.

INSTRUCTIONS

i) The Medical Examiner must be a duly registered Medical Practitioner.
ii) The form should be completed using BLOCK LETTERS.
iii) This form, once completed, should be sealed by the Medical Examiner and sent together with the application form to the Institute.

PART A: PERSONAL DETAILS (To be filled by the applicant)

1. SURNAME /FAMILY NAME: _____
2. OTHER NAMES: _____
3. DATE OF BIRTH: _____ GENDER: _____
4. NATIONALITY: _____ ID/PASSPORT NO. (If applicable): _____

Known condition and medication taken if any _____

_____

1	Allergies	
2	Illness	
3	Medication	

A PERSONAL HISTORY

	Have you ever suffered from any of the following	Yes	No	Details of treatment if any
1	Any ear, nose and throat disorder			
2	Asthma, bronchitis ,TB or any other lung disease			
3	Epilepsy or any neurological disorder			
4	Anxiety, depression or any other mental disorder			
5	Gastrointestinal, gall bladder or liver disorder			
6	Hypertension, Angina, Heart or Rheumatic fever			
7	Diabetes			
8	Kidney, bladder or any other genital urinary disorder			
9	Joint injury or disorder, arthritis or gout			
10	Any enlarged glands, tumors, growths or cancers			
11	Any fracture of bones or internal fixations done			
12	Undergone any surgical operation and if so which one			
13	Any significant disease or injury not mentioned above			
14	Taken alcohol in the last one month. State number of units per week.			
15	Smoked cigarettes in the last one month, or any form of tobacco.			

PART B: DECLARATION (to be filled by the applicant in presence of the medical practitioner)

I certify that I am not, to my knowledge suffering from any physical disability of which I have not informed the medical examiner and that the statements made and information given to the medical examiner is correct

(Applicant's Signature): _____ (Date)_____

PHYSICAL EXAMINATION

General:

Appearance:_____

Height:_____ Weight:_____ BMI:_____

EYES: Vision-Right eye without spectacles:_____ Left eye without spectacles:_____

Visual acuity:_____

EARS: Right ear:_____ Ear drum:_____

Left ear:_____ Ear drum:_____

Nose, mouth and neck:

Nose:_____ Tongue:_____ pharynx:_____ Teeth:_____ Tonsils_____ Thyroid:_____

CARDIOVASCULAR SYSTEM: Pulse:_____ Blood pressure:_____ Varicose veins:_____

RESPIRATORY SYSTEM: Respiratory rate:_____ Breath sounds:_____ Breasts:_____

DIGESTIVE SYSTEM: Abdomen:_____ Liver:_____ Spleen:_____ Hernia:_____ Hemorrhoids:____

NERVOUS SYSTEM: Reflexes:_____ Pupils to light:_____

Motor function_____

SKELETALSYSTEM: _____

_____

CONCLUSION:_____

_____

RECOMMENDATION:_____

_____

_____

CLINICIAN:

NAME:_____ DESIGNATION:_____

SIGNATURE:_____ DATE:_____

STAMP:_____