UGANDA HEALTH PROFESSIONS ASSESSMENT BOARD

Plot 157, Ssebowa Rd, Kiwatule, Kampala, P.O.Box 236 Ntinda, Tel: 0393000638,
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Ministry of Education and Sports

SEMESTER ASSESSMENT REGISTRATION FORM

Affix photo here

A. INSTRUCTIONS

1. Write your Name clearly in capital letters and in the order of appearance on previous academic documents. (Attach copies of previous academic documents)
2. Attach 1 recent coloured passport size photograph on this form. (The photo must have a white background and Trainee in uniform)
3. Diploma candidates should indicate whether they are Direct entrants, Extensors or E-learners.
4. This form **MUST** be authenticated by the Health TVET Provider Institution and Training Hospital where applicable
5. Forms should be submitted to UHPAB Secretariat in the 1st week of March for June Assessment series and 1st week of September for December Assessment series.
6. Proof of payment of Assessment Registration fees should be attached
7. All retaking candidates should fill **TWO** forms, one for the continuing assessment schedule and another for the retake assessment schedule. All retaking candidates must pay for retake the schedules.
8. All fields with a star(*) are mandatory and therefore must be filled

B. HEALTH TRAINEE IDENTIFICATION

Health TVET Provider Institution*: _____

Assessment Centre Code*: _____ Month and Year of enrollment*: _____

Surname*: _____ First Name*: _____ Other Name: _____

Sex*: _____ Date Of Birth (dd/mm/yy) *: _____ Telephone*: _____

Email*: _____ HTIN Number*: _____

National Identification Number: _____ Passport Number: _____

Learner Identification Number*: _____ Student's Signature*: _____

C. ASSESSMENT REGISTRATION INFORMATION

Program* _____

Year of Study*: _____ Semester*: _____

Please Tick where Appropriate*: 1st Attempt ☐

2nd Attempt ☐ Paper(s): ....., ...

3rd Attempt ☐ Paper(s): ....., ...

FOR UHPAB OFFICIAL USE ONLY

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D. **CERTIFICATE OF GOOD CONDUCT *** (To be filled by Principal of Heath TVET Provider Institution)

I certify that I have known and interacted with* ..... for a period of* ..... and that she/he is trustworthy and of good character.

Name*: ..... Signature*: ..... Date*: .....
(Affix official stamp of the Health TVET Provider Institution).

E. PRACTICAL FIELD PROGRESS REPORT* (To be filled by the head of Department in the Hospital)

Trainee's Name*: Program*:

Health TVET Provider Institution*

HTIN No*: Date of commencement of placement*:

Date of completion*:

F. SOFT SKILLS ASSESSMENT REPORT* (To be filled by Mentor in practicum site)

	SOFT SKILL	COMMENT
1.	Punctuality	
2.	Accuracy and tidiness	
3.	Ability to communicate appropriately to stakeholders	
4.	Ability to observe and assess a situation	
5.	Obedience – responds to instructions	
6.	Ability to apply required skills	
7.	Ability to cope with emergencies	
8.	Ability to plan and organize	
9.	Ability to control emotional reactions	
10.	Ability to work without direct supervision	
11.	Ability to respect confidentiality and uphold the dignity of the patient	
12.	Self confidence	
13.	Attitude towards	
	a. Clients/patients	
	b. staff	
	c. visitors	
	d. Learning	

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Name of Practicum Site*: .....

Name of Mentor*/Supervisor: ..... Tittle*: .....

Signature*: ..... Date*: ..... *(Affix Stamp*)*