FEDERAL UNIVERSITY OF TECHNOLOGY, AKURE

REGISTRATION FORM FOR ADMISSION TO THE UNIVERSITY HEALTH CENTRE

1. NAME OF STAFF .....
(Surname First)

2. SCHOOL/DEPARTMENT: .....

3. STATUS: .....

4. DATE OF FIRST APPOINTMENT:.....

5. MARITAL STATUS: .....

6. NAME OF WIFE/WIVES:.....

7. NAMES, AGES AND SEX OF CHILDREN (Please attach passport photographs)

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8. NAME AND ADDRESS OF NEXT OF KIN: .....

..... Tel. No: .....

9. I certify that the information stated above is true.

....
Date Signature

10. (To be completed by Head of Department)

I confirm that the information contained above is to the best of my knowledge

....
Date Signature

11. Certificate

I hereby certify that the above information tallies with the information submitted by the Officer in his/her personal Data Records on assumption of duty.

....
Date Registrar's Signature