UNIVERSITY OF MEDICAL SCIENCES

P.M.B. 536, LAJE ROAD, ONDO CITY, ONDO STATE

CAPACITY DEVELOPMENT REQUEST FORM

Name: .....

Designation: .....

Department: .....

Type of Course		**Course Details**
Training	☐	Title: .....
Workshop	☐	Location: .....
Conference	☐	Venue: .....
Seminar	☐	Date/Duration: .....
Others	☐	Course Fees: .....

Have you secured any financial support for this course? ..... **If yes, specify source/amount of funds:**

.....

.....

Do you require University Support for this course? ..... **If yes, specify the total amount of funds required:** .....

Signature: ..... **Date:** .....

Have you ever received University support in the past 5 years? ..... **If yes, how many times have you received support?** .....

Give details of last course attended (Course title, Fin. support, Date and Location):

HODs Comment/Approval: .....

HODs Name: ..... **Sign:** .....

Dean's Comment/Approval: .....

Dean's Name: ..... **Sign:** .....

VC's Comment/Approval: .....

Vice-Chancellor: ..... **Sign:** .....