MINISTRY OF EDUCATION
STATE DEPARTMENT OF VOCATIONAL AND TECHNICAL TRAINING
PETER AMOR TECHNICAL TRAINING INSTITUTE
P.O BOX 30121-00100 Westlands , Nairobi
Email: peteramortechnical@gmail.com
Tel: +254 798 396 271

LETTER OF OFFER

PATTI/……/2025 **DATE: ……**

ADMISSION NO: ……

Dear(Student Name) ……

APPLICATION FOR ……
I am pleased to inform you that your application for the above course has been successful and the details of the course are as follows;
FIRST SEMISTER START DATE: ……

1. INSTITUTE ACCESS

The institute is located in **Nairobi** county,**Westlands** along the Parkland Ring Road,near Sarit Centre. I wish you a safe journey to Peter Amor Technical Training Institute and good success in your studies. **WELCOME ALL.**

2. GENERAL REQUIREMENT

(a) ALL STUDENTS TO COME WITH:

- Two recent passport size photographs
- Certified Medical Certificate
- Copies of Academic Certificates and Originals for Certification and Confirmation (KCSE,KCPE,IDENTITY CARD,HIGH SCHOOL LEAVING CERTIFICATE)

- Adequate writing material
- One spring file
- One ream of photocopy papers

(b) REQUIREMENT FOR ONLY BOARDING STUDENTS.

- Beddings (bedsheets,duvet,pillow)
- Personal effects

NB: Additional Requirements must be brought on reporting date.

3. STUDENTS MEDICAL CERTIFICATE

NOTE: Application for entry to the institution MUST get this form completed by a REGISTERED DOCTOR.

Name of student…….. County……

Eyes and Vision Unaided Right-Left Aided Right-Left Colour blind visual field	
Nose And Throat Is Nasal Breathing Habitual?	
Ears Hearing voice -Right -Left	
Mouth And Teeth	
Glands in the neck	
Chest,Heart,Lungs-with reference to any tubercular tendencies	
Spinal Column	
Urine,Stool	
Spleen,Liver Piles And Vericose veins	
Any other weaknesses,defects or disease defects or span,veneral,rheumatic tendency	
General observations: If care is desirable in any special direction. Please give particulars	

NAME AND RUBBER STAMP OF REGISTERED DOCTOR…….

ADDRESS……..TOWN……

DATE……SIGNATURE……..

NB: The institution offers first aid treatment to students. In case of ANY referrals,the cost of treatment shall be passed over to the parent/guardian

PARENT

SIGNATURE……..DATE……..PHONE NUMBER……..ADDRESS……..

KINDLY MAKE YOUR OWN COPY OF THIS LETTER BEFORE SUBMISSION