UNIVERSITY OF IBADAN  
THE POSTGRADUATE SCHOOL  
SCHOLARSHIP APPLICATION FORM FOR POSTGRADUATE  
STUDENTS LIVING WITH PHYSICAL DISABILITY  

PLEASE PRINT ALL ENTRIES

1. Surname: ............................................Other Names: ...................................................

2. Sex: Male ( ) Female ( )  3. Date of Birth: ......................

4. Nationality ......................................

5. Nature of physical disability .........................................................................................

6. Department/Faculty/Institute: ......................................................................................

7. E-mail: .............................................8. Telephone No. ..............................................

9. Universities attended with dates:
   i. .................................................................................................................................
   ii. .................................................................................................................................
   iii. .................................................................................................................................

10. Class of First Degree and date obtained:.........................

11. Master Degree and date obtained (If Applicable)....................... 
    ....................................................................................................................................

12. Overall Weighted Average Score/ CGPA at Master Degree Level: ..............

13. Scholarships, Fellowships and Prizes Received in the Past or Presently being Enjoyed:
   i .................................................................
   ii. .................................................................
   iii. .................................................................
15. Proposed title of PhD thesis (If Applicable)………………………………………

……………………………………………………………………………………………

16. Supervisor(s): ………………………………………………………………………

17. Date of 1st registration for the Current Programme (If Applicable):………………

18. Sponsorship: Give name and contact address of your sponsor:

(i) Name: ……………………………………………: ……………………………

Contact Address:………………………………………………………………………

…………………………………………………………………………………………

19. Give any other information you consider relevant to this application:……………

……………………………………………………………………………………………

Applicant’s Signature …………………………………………………………………

Date …………………

Comments of the Head of Department: …………………………………………………

…………………………………………………………………………………………

Signature …………………………………………………………………………………

Date …………………

Comments of the Dean/Director of Faculty/Institute: ……………………………..

…………………………………………………………………………………………

Signature …………………………………………………………………………………

Date …………………

IMPORTANT NOTICE

1. This form may be filled by proxy for applicants suffering from blindness.

2. Please attach copies of ALL your credentials, certification by the Director, University of Health Services confirming nature of disability, PhD proposal (where applicable), and evidence of registration for the current session (where applicable) to this application form.