*FORM C*

# WEST AFRICAN COLLEGE OF PHYSICIANS

(TWO)
PASSPORT
PHOTOGRAPHS

## APPLICATION FOR MEMBERSHIP and FELLOWSHIP EXAMINATIONS

*FOR OFFICIAL USE ONLY*

Date Received _____ Amount Paid _____Teller No. _____

Receipt No. _____ Approved By _____ Examination No. _____

**Preferred Examination Centre**: ( **Accra**), (**Ibadan)**

**FACULTY**: .....**PART** : ..... **DATE OF EXAMINATION**: .....

## GENERAL INFORMATION

1. **SURNAME** (*in **BLOCK** letters*) .....
2. **OTHER NAMES**: .....
3. **MAIDEN NAME:** (*if any*) .....
4. **DATE OF BIRTH:** ..... **Sex:** ..... **Nationality:** .....
5. **ADDRESS:** (*to which Examination notice should be sent*) .....

   .....

   .....

5 **E-mail address:** **Tel. No**

**Instructions and Notices**

a. ***This form, when fully completed, must be returned as early as possible but not later than the advertised closing date to the Secretary General, WACP, 6 Taylor Drive, Off Edmund Crescent, PMB 2023, Yaba, Lagos State – cexaminations@yahoo.com***

b. ***All Payments should be made at any GUARANTY TRUST BANK Branch countrywide in Nigeria. Candidates should pay into Account No.* 0028724798 *in the name of WEST AFRICAN COLLEGE OF PHYSICIANS" Candidates must indicate their names in the Teller Column 'Paid By' and the duplicate Teller indicating the candidate's Faculty, & Part. All will be submitted along with the Examination Application Form to the College Secretariat. It is the duty of the candidate to find out the equivalent of the Examination Fee in his/her home currency at the time of submission of the application .Candidate for Accra centre should pay through Western Union Money Transfer and call Mr. Okletey on +233275091659 or +233246153624***

c. ***Copies of relevant professional certificates (see items 7, 8, 9 below),Log Book - ( Photocopy). Fellowship - Case Book/Dissertation – (All faculties), Autopsy Reports for Laboratory Medicine, Membership, two passport size photographs, Bank Teller indicating – Name - Part & Faculty and Three self addressed stamped envelopes must be attached.***

d. ***DEFERMENT OF EXAMINATION AFTER SUBMISSION OF FORMS OR APPLICATION FOR REFUND ARE NO LONGER ACCEPTABLE.***

e. ***Examination scripts are the property of the College and shall normally be destroyed two years after the examination.***

## SPECIFIC DETAILS

6. Faculty Examination for which candidate wishes to appear (*Please Mark X in the appropriate Box*)

| | Faculties | | Sub-Speciality (*where applicable*): |
|---|---|---|---|
| 1. | COMMUNITY HEALTH | | |
| 2. | FAMILY MEDICINE | | |
| 3. | INTERNAL MEDICINE | | |
| 4. | LABORATORY MEDICINE | | |
| 5. | PAEDIATRICS | | |
| 6 | PSYCHIATRY | | |

7. Medical School Attended & Year of Graduation: .....

.....

8. Institution(s) & Dates of Postgraduate Training (*attach Certificate(s) of Training*):

   1. .....
   2. .....
   3. .....

9. Date of previous Fellowship Examinations passed: (*attach photocopies of Certificates or Notice of Results*)

   Primary .....

   Part I .....

10. Any previous attempt at this Examination ? Yes/No.

    *If yes*, list dates: 1. ..... 3 .....

    2. ..... 4. .....

    5. ..... 6. .....

11. Signature of Candidate *(with date)*: .....

12. Name of Head of Department: .....

13. Signature of Head of Department *(with date)*: .....

14. Preferred Examination Centre (*Circle as appropriate*0 **Ibadan/Accra**

**RECOMMENDATION**

Recommendations by Two **Fellows** in good standing with the College at least **ONE** of whom must be a Fellow of the relevant Faculty:

A. *I hereby certify that ..... is personally known to me and I consider him/her to be in every way suitable for admission into the Fellowship examination of the College.*

..... ..... .....

*Name* *Signature* *Date*

B. *I hereby certify that ..... is personally known to me and I consider him/her to be in every way suitable for admission into the Fellowship examination of the College.*

..... ..... .....

*Name* *Signature* *Date*

*FORM C*

# WEST AFRICAN COLLEGE OF PHYSICIANS

## CERTIFICATE OF TRAINING

**NAME:** ..... .....

**PRESENT POSTAL ADDRESS:** ..... ..... .....

**FACULTY/SPECIALISATION** ..... **TRAINING**..... **INSTITUTION:**.....

| | Posting/Appointment | Date Commenced | Date Completed | Duration of Training | Name and Signature of Supervising Consultant (*with dates*) | Remarks |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

*I certify that the information given above is correct to the best of my knowledge.*

| ..... | ..... | ..... |
|---|---|---|
| **CANDIDATE** | **HEAD OF DEPARTMENT** | **DEPARTMENT OF TRAINING/MEDICAL DIRECTOR** |
| (*Signature & Date*) | (*Signature, name, date and Official Stamp*) | (*Signature, Name, Date and Official Stamp*) |

***NOTES***:
1. *It is the duty of and responsibility of the candidate/trainee to acquaint himself/herself of the current rules on the type, duration and minimum number of rotations required before admission into any part of the Fellowship examinations in his/her speciality.*
2. *Where candidate/trainee trains in more than one institution, a certificate of training must be obtained from each Institution.*
3. *Photocopies of certificates previously submitted to the College may be appended to newly obtained certificate(s).*