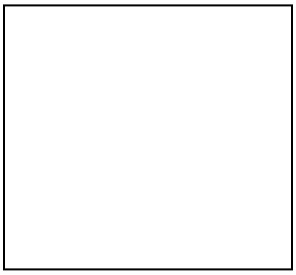
WEST AFRICAN COLLEGE OF PHYSICIANS

6, TAYLOR DRIVE, OFF EDMUND CRESCENT,
MEDICAL COMPOUND, P. M. B. 2023, YABA, LAGOS.
TEL:-+234 08176673531 - 2



APPLICATION FOR REGISTRATION AS A PHYSICIAN IN TRAINING

This form should be accompanied by the following:

a. A passport photograph.
b. Copies of relevant certificates, i.e., MBBS, NYSC, MDCN, Primary Result of WACP or NPMCN, etc.
c. N72, 200.00 or ($190) in favour of the West African College of Physicians **(from Guaranty Trust Bank, Account No: 0028724808). Payment of cash is not acceptable.**

1. FULL NAME:……
(Surname First)
2. DATE OF BIRTH:……NATIONALITY:……
3. CURRENT POSTAL ADDRESS **(*P.O. Box not acceptable*)……**

……

Tel/Gsm …….. *Email*……..

4. QUALIFICATIONS WITH DATES AND NAMES OF AWARDING INSTITUTIONS:

……..

……..

……..

5. DATE OF FULL REGISTRATION AS A MEDICAL PRACTITIONER:

……

……

6. SPECIALTY/FACULTY:……

7. APPOINTMENTS SINCE QUALIFICATION (Give Date):……..

……..

8. POSTGRADUATE EXAMINATIONS PASSED (Give Date):……
……

……

9. DATE STARTED POSTGRADUATE TRAINING: (Give Date) ……
(Evidence of Commencement of Training (that is: Certificate of Postings)

……
I certify that the above information is correct.

…… …… …….
NAME SIGNATURE & DATE

SECTION B:

(To be filled in by the Applicant's Head of Department)

I certify that the above information is correct.

…… …….
NAME SIGNATURE & DATE
(Official Stamp)

SECTION C:

To be filled in by a Fellow of the West African College of Physicians (other than the Head of Department).

I certify that Dr……
has the professional, ethical and moral standards required of a Fellow of the West African College of Physicians.

…… …….
NAME SIGNATURE & DATE