

WEST AFRICAN COLLEGE OF PHYSICIANS
6, Taylor Drive, Off Edmund Crescent,
P. M. B. 2023, Yaba.
Lagos, Nigeria

(TWO)
 PASSPORT
 PHOTOGRAPHS

FORM OF ENTRY TO COLLEGE EXAMINATIONS

Instructions & Notices

- a. *This form, when fully completed, must be returned to the Secretary General, WACP as early as possible at the address above but not later than the advertised closing date.*
- b. *All payments should be made at any **GUARANTY TRUST BANK** Branch with **ONLINE** facilities in Nigeria. Candidate 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 also indicate their faculty and Part. The duplicate Teller indicating will be submitted along with the Examination Application Form to the College Secretariat..Candidates for Accra centre should pay through **GTB Money Transfer** and call Mr. Oklety on +233275091659*
- c. *Copies of relevant professional certificates (see items 8, 9, 1, 11 below) and two passport size photographs with **THREE** self addressed (stamped) Envelope 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.*

GENERAL INFORMATION

1. **Surname:** (Block Capitals)

2. **Other names:** (Block Capitals).....
3. **Maiden Name:** (If any)

4. **Residential Address:**

5. **Postal Address** (if different from above)

6. **E-mail address:**.....
7. **Telephone No.**
8. **Date of Birth:**
9. **Sex:**
10. **Nationality:**
11. **Professional and University Name of University/ College: Date:**
Qualifications:

12. **Date of full registration with National Medical Council/Board**

13. **Date of Discharge from NYSC Programme or Rural Service as applicable:**
14. **Post-registration Appointments:**

15. SPECIFIC INFORMATION

Faculty to which application is being made. (Mark **X** in the appropriate box).

WACP Faculties

<input type="checkbox"/>	COMMUNITY HEALTH
<input type="checkbox"/>	FAMILY MEDICINE
<input type="checkbox"/>	INTERNAL MEDICINE
<input type="checkbox"/>	LABORATORY MEDICINE
<input type="checkbox"/>	PAEDIATRICS
<input type="checkbox"/>	PSYCHIATRY

16. **Name of Institution:**
17. **Date of Examination applied for**
18. **Preferred Examination Centre:** (Tick[] as appropriate)

<input type="checkbox"/>	ACCRA
<input type="checkbox"/>	BANJUL
<input type="checkbox"/>	ENUGU

<input type="checkbox"/>	FREETOWN	<input type="checkbox"/>	ZARIA
<input type="checkbox"/>	IBADAN	<input type="checkbox"/>	
<input type="checkbox"/>	MONROVIA	<input type="checkbox"/>	

19. Previous attempts at the Primary Fellowship Examination?

Nil

	Date
1	
2	
3	
4	
5	

20. I hereby attest that all the information above are true and correct. Any false information will lead to sanctions

Candidate's Signature 19a. Date:

21. CERTIFICATION

FOR THE CANDIDATE'S CURRENT HEAD OF DEPARTMENT or SUPERVISING CONSULTANT

I certify that the candidate has satisfactorily worked in my Department/Unit

from to

Signature:..... Date:

Qualifications:

Full Name:

Address:

.....

<i>For Office Use Only</i>	<i>Action By</i>	<i>Signature</i>
Date Application received.....	Examination Officer
Date Application Checked.....	Accountant
Fees paid	Faculty Officer
Exam. No.	Secretary General

Website: www.wac-physicians.org

FORM A

WEST AFRICAN COLLEGE OF PHYSICIANS



APPLICATION FOR ADMISSION TO PRIMARY FELLOWSHIP EXAMINATIONS

FOR OFFICIAL USE:

EXAMINATION DATE

FEE PAID:

TELLER NO/DATE:

RECEIPT NO.:

EXAMINATION NO. :

EXAMINATION CENTRE:

NB: PLEASE TICK THE PREFERRED CENTRE FOR THE EXAMINATION:
(Changing of Centre after submission of form will not be ENTERTAINED)