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 SUB-SPECIALIST IN TRAINING

This form should be accompanied by the following:

a. A Passport photograph.
b. Copies of relevant certificates, i.e. MWACP result, MBBS, NYSC, MDCN etc.
c. (N146,300) or ($385) in favour of the West African College of Physicians **(Guaranty Trust Bank, Account No: 0028724808). Payment of cash is no longer 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. FACULTY/ SUBSPECIALTY:………………………………………………………………………

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

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

8. MWACP PASSED (Give Date): ……………………………………………………………….

9. CENTRE FOR SUBSPECIALTY TRAINING:……………….………………………………

10. DATE STARTED SUBSPECIALTY TRAINING:……………………………………………

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