WEST AFRICAN COLLEGE OF PHYSICIANS

APPLICATION FOR MEMBERSHIP and FELLOWSHIP EXAMINATIONS

OR OFFICIAL USE ONLY

Date Received __________________ Amount Paid __________________ Teller No. __________________

Receipt No. __________________ Approved By __________________ Examination No. __________

Preferred Examination Centre: ( Accra), (Ibadan) and ( Abuja)

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) ........................................................................

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

Instructions and Notices

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, No. 8 Thorborn Avenue Sabo-Yaba, Lagos. – wacpexams@wac-physicians.org

<table>
<thead>
<tr>
<th>FEES</th>
<th>ALL EXAMINATIONS FEES ARE PAYABLE ELECTRONICALLY</th>
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<tbody>
<tr>
<td><strong>EVIDENCE OF PAYMENT</strong></td>
<td>Candidates applying for primary, membership and fellowship examinations should log on to <a href="http://www.wac-physicians.org">www.wac-physicians.org</a> and follow the step by step procedure for online registration which could be printed as evidence of payment. <strong>BANK DRAFTS AND TELLER ARE NO LONGER ACCEPTABLE FOR EXAMINATION APPLICATION.</strong></td>
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| **APPLICANTS NOT RESIDING IN NIGERIA:** | 1) **Ghana:** Should pay (in the name of West African College of Physicians) into GCB Bank (Korle-Bu Branch) Account No. 1131130009095. The PAY-IN-SLIP should be submitted to the College Office for a UNIQUE PAYMENT CODE which will be needed to complete the ONLINE REGISTRATION.

2) **Other Countries:** Should start application process online and pay in USD. |
SPECIFIC DETAILS

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

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<tr>
<th>Faculties</th>
<th>Sub-Speciality (where applicable):</th>
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<tbody>
<tr>
<td>1. COMMUNITY HEALTH</td>
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<td>2. FAMILY MEDICINE</td>
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<td>3. INTERNAL MEDICINE</td>
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<td>4. LABORATORY MEDICINE</td>
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<td>5. PAEDIATRICS</td>
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<td>6. PSYCHIATRY</td>
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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) Ibadan/Accra/Abuja

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
# WEST AFRICAN COLLEGE OF PHYSICIANS
## CERTIFICATE OF TRAINING

**NAME:** 

**PRESENT POSTAL ADDRESS:** 

**FACULTY/SPECIALISATION** 

**TRAINING** 

**INSTITUTION:** 

<table>
<thead>
<tr>
<th>Posting/Appointment</th>
<th>Date Commenced</th>
<th>Date Completed</th>
<th>Duration of Training</th>
<th>Name and Signature of Supervising Consultant (with dates)</th>
<th>Remarks</th>
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I certify that the information given above is correct to the best of my knowledge.

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**CANDIDATE**

**HEAD OF DEPARTMENT**

**DEPARTMENT OF TRAINING/MEDICAL DIRECTOR**

**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 specialty.
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).