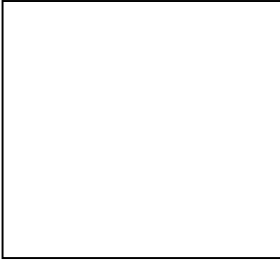


WEST AFRICAN COLLEGE OF PHYSICIANS

6, TAYLOR DRIVE, OFF EDMUND CRESCENT, MEDICAL COMPOUND, YABA, LAGOS
Office Annex: 8 THORBORN AVENUE, SABO, YABA, LAGOS, P. M. B. 1021, YABA, LAGOS
TEL:-+234 08176673531 - 2

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www.wac-physicians.org



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. **Pay online via [College Website](#). (Please Payment to the bank or transfer is NO LONGER acceptable).** N95,000.00 or (\$190) in favor of the West African College of Physicians

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