WEST AFRICAN COLLEGE OF PHYSICIANS

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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.
Pay online via College Website. ((**Please Payment to the bank or transfer is NO LONGER acceptable).**

1.
c. FULL NAME:…….
(Surname First)

2. DATE OF BIRTH:……..…….

3. CURRENT ADDRESS ***(P.O. Box not acceptable)***……

(Where correspondences should be sent) ……

……..

Tel/Gsm …….. *Email*……

4 . QUALIFICATIONS WITH DATES AND NAMES OF AWARDING INSTITUTIONS:

…….

……..

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5. DATE OF FULL REGISTRATION AS A MEDICAL PRACTITIONER:

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6. FACULTY/ SUBSPECIALTY:……

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

……..

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……..

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

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