*FORM C*

# WEST AFRICAN COLLEGE OF PHYSICIANS

(TWO)
PASSPORT
PHOTOGRAPHS

## APPLICATION FOR MEMBERSHIP and FELLOWSHIP EXAMINATIONS

*FOR OFFICIAL USE ONLY*

Date Received ________________ Amount Paid ____________________Teller No. ____________________

Receipt No. _________________ Approved By __________________ Examination No. _____________

**Preferred Examination Centre**: ( **Accra**), (**Ibadan**) **,** ( **Abuja**) and (**Banjul/Monrovia/Freetown – (Paper and pencil examination)**

**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**

a. ***This form, when fully completed, must be uploaded as early as possible but not later than the advertised closing date via WACP website.***

| **FEES** | **ALL EXAMINATIONS FEES ARE PAYABLE ELECTRONICALLY** |
|---|---|
| **EVIDENCE OF PAYMENT** | Candidates applying for primary, membership and fellowship examinations should log on to https://www.wacpcoam.org and follow the step-by-step procedure for online registration which could be printed as evidence of payment. **BANK DRAFTS AND TELLER ARE NO LONGER ACCEPTABLE FOR EXAMINATION APPLICATION.** |
| **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.<br>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*)

| | Faculties | | Sub-Speciality (*where applicable*): |
|---|---|---|---|
| **1.** | **COMMUNITY HEALTH** | | |
| **2.** | **FAMILY MEDICINE** | | |
| **3.** | **INTERNAL MEDICINE** | | |
| **4.** | **LABORATORY MEDICINE** | | |
| **5.** | **PAEDIATRICS** | | |
| **6** | **PSYCHIATRY** | | |

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*0 **Ibadan/Accra/Abuja/ Banjul/Monrovia/Freetown**

**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*

*FORM C*

# WEST AFRICAN COLLEGE OF PHYSICIANS

## CERTIFICATE OF TRAINING

**NAME:** ........................................................................................ ........................................................................................................................

**PRESENT POSTAL ADDRESS**: ......................................................... ................................................................................ .............................

**FACULTY/SPECIALISATION** ............................................. **TRAINING**............................................. **INSTITUTION**:...................................

| | Posting/Appointment | Date Commenced | Date Completed | Duration of Training | Name and Signature of Supervising Consultant (*with dates*) | Remarks |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

*I certify that the information given above is correct to the best of my knowledge.*

................................ ................................................................... .............................................................................................

**CANDIDATE** (*Signature & Date*)

**HEAD OF DEPARTMENT** (*Signature, name, date and Official Stamp*)

**DEPARTMENT OF TRAINING/MEDICAL DIRECTOR** (*Signature, Name, Date and Official Stamp*)

***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 speciality.*
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).*