

WEST AFRICAN COLLEGE OF PHYSICIANS

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Affix Passport

FELLOWSHIP CERTIFICATION FORM

FORM A

NOTE: All information should be filled in capital letters

SECTION A

Name.....
(Surname First)

Maiden Name (*where applicable*)

Current Address: (P.O.Box not acceptable):.....
.....

Permanent Address.....
.....

Telephone..... Email

Date of Pass: (Attached statement of result) Fellowship Exams No.....

Faculty..... Subspecialty (If applicable)

.....
Signature and Date

SECTION B:

(To be filled in by your Head of Department).

I certify that the above information is correct.

.....
Full Name

.....
Signature & Date
(Official Stamp)

SECTION C:

(To be filled in by a Fellow of the West African College of Physicians in good standing (other than the Head of Department))

I certify that the above information is correct.

.....
Signature and Date

.....
Full Name

.....
Year of Fellowship