WEST AFRICAN COLLEGE OF PHYSICIANS

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Affix Passport

MEMBERSHIP CERTIFICATION FORM

FORM B

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) …… Membership Exams No……..

Faculty…… Physician in Training Number……..

……
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 financial standing (other than the Head of Department)

I certify that the above information is correct.

……..
Signature and Date

…… ……..
Full Name Year of Fellowship