WEST AFRICAN COLLEGE OF SURGEONS

(TWO) PASSPORT PHOTOGRAPH

APPLICATION FOR PART I *&* PART II (FINAL) FELLOWSHIP EXAMINATIONS

FOR OFFICIAL USE ONLY

Date Received		**Amount Paid**		**Teller No.**	
Receipt No.		**Approved By**		**Examination No**	

Tick [✓] Preferred Examination Centre: [ ] Accra, [ ] Ibadan

FACULTY: ..... **PART**:……..... **DATE OF EXAMINATION**:……

GENERAL INFORMATION

1. **SURNAME** (*in **BLOCK** letters*) ……. ....
2. **OTHER NAMES**: ……..... ....
3. **MAIDEN NAME:** (*if any*) ..... **Training Institution**.....…….
4. **DATE OF BIRTH:** ……. **Sex:** ..... **Nationality:** ……
5. **ADDRESS:** (*to which Examination notice should be sent*) ……..... .....

   ……..... .....

   Permanent Address (*if different from Above*) ..... …….. ....

   ……..... .....

5. **E-mail address:** ……..…… **Tel. No.**… …… ……

Instructions and Notices

a. ***This form, when fully completed, must be returned as early as possible but not later than the advertised closing date to the Secretary General, WACS, 6 Taylor Drive, Off Edmund Crescent, PMB 1067, Yaba, Lagos State – Telephone No. 08172011629***

b. ***All Payments should be made at any UNITED BANK OF AFRICA Plc (UBA), with online facilities to ACCOUNT NO.* 1014816816, *ACCOUNT NAME - "WEST AFRICAN COLLEGE OF SURGEONS " Candidates must indicate their names in the Teller Column 'Paid By' and the duplicate Teller indicating the candidate's Faculty, & Part. All will be submitted along with the Examination Application Form to the College Secretariat***

c. ***Copies of relevant professional certificates (see items 7, 8, 9 below), Spiral bound Log Books(Parts I & II), Case Book/Dissertation – (Anaesthesia, Dental Surgery & Obstetrics & Gynaecology), two passport size photographs, Bank Teller indicating – Name - Part & Faculty and Three self addressed stamped envelopes must be attached.***

d. ***DEFERMENT OF EXAMINATION AFTER SUBMISSION OF FORMS OR APPLICATION FOR REFUND ARE NO LONGER ACCEPTABLE***

e. ***Examination scripts are the property of the College and shall normally be destroyed two years after the examination.***

SPECIFIC DETAILS

6. Faculty Examination for which candidate wishes to appear (*Please Mark X in the appropriate Box*)

	Faculties	**Tick (X)**	**Sub-Speciality** (*where applicable*):
1.	**ANAESTHESIA**		
2.	**DENTAL SURGERY**		
3.	**OBSTETRICS & GYNAECOLOGY**		
4.	**OPHTHALMOLOGY**		
5.	**OTORHINOLARYNGOLOGY**		
6	**RADIOLOGY**		
7.	**SURGERY**		

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. *I declare that the statements made in this application are to the best of my knowledge correct and complete and I accept that any statement found to be false may render me liable to disqualification from the examination and other sanctions.*

Candidate's Signature ..... Date: .....

13. Name of Head of Department: .....

14. Signature of Head of Department *(with date)*: .....

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*

WEST AFRICAN COLLEGE OF SURGEONS

CERTIFICATE OF TRAINING

APRIL 2017 EXAMINATIONS APPLICATION-PARTS I & II

NAME: …… …… ……

PRESENT POSTAL ADDRESS: …… ……

FACULTY/SPECIALITY …… **TRAINING INSTITUTION:**……

	Posting/Appointment	Date Commenced (dd/mm/yyyy)	Date Completed (dd/mm/yyyy)	Duration of Training	Name and Signature of Supervising Consultant (*with dates*)	Remarks
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

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*)

HEAD OF TRAINING INSTITUTION/CHIEF 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 should be appended to newly obtained certificate(s).*