WEST AFRICAN COLLEGE OF SURGEONS

6, TAYLOR DRIVE OFF EDMUND CRESCENT MEDICAL COMPOUND
PMB 1067, YABA LAGOS
TEL: 081-72011627, 081-72011630

APPLICATION FOR REGISTRATION AS A SURGEON-IN-TRAINING

N.B.

i. A copy of this Surgeon in Training form must be attached to your Part I Fellowship Examination Form on submission

1. FULL NAME:_____
   (Surname First)
2. DATE OF BIRTH**:**_____
3. CURRENT CONTACT ADDRESS:_____
   _____
4. TELEPHONE NO (Mobile)_____
   (Home)_____
5. E-mail Address**:**_____
5. NAME OF INSTITUTION WITH FULL ADDRESS_____
   _____
6. QUALIFICATIONS WITH DATES AND NAMES OF AWARDING INSTITUTIONS
   _____
   _____
7. DATE OF FULL REGISTRATION AS A MEDICAL PRACTITIONER
   _____
8. SPECIALTY/FACULTY_____
9. APPOINTMENTS SINCE QUALIFICATION (give Date)
   _____

_____

10. POSTGRADUATE EXAMINATIONS PASSED (Give Date)

_____

_____

11. DATE STARTED POSTGRADUATE TRAINING:_____

12. INDICATE DATE/YEAR INTENDED TO TAKE WACS EXAMINATION

_____

I certify that the above information is correct

_____ _____

NAME SIGNATURE AND DATE

SECTION B:

(To be completed in by the Applicant's Head of Department)

I certify that the above information is correct.

Name:_____

Qualification:_____

Contact Address:_____

Telephone No (Mobile)_____

(e-mail)_____

Signature, Dates and Stamp_____

SECTION C

(To be completed by a Fellow of the *West African College of Surgeons in good financial standing with the College).*

I certify that Dr. _____
Has the professional and ethical standards required of a Fellow of the West African College of Surgeons.

Name: _____

Contact Address:_____

Telephone No (Mobile) _____

(E-mail)_____

Signature & Dates _____