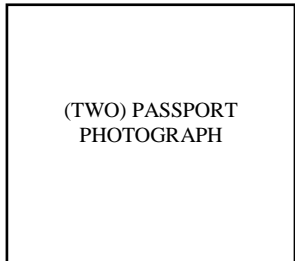


WEST AFRICAN COLLEGE OF SURGEONS



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

FOR OFFICIAL USE ONLY

Date Received	
Receipt No.	

Amount Paid	
Approved By	

Teller No.	
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.



WEST AFRICAN COLLEGE OF SURGEONS

CERTIFICATE OF TRAINING

EXAMINATIONS APPLICATION FORM C. FOR 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 (<i>with dates</i>)	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).