

# WEST AFRICAN COLLEGE OF SURGEONS



(TWO) PASSPORT PHOTOGRAPH

## **APPLICATION FOR PART I *and* 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. 01-7737019
- b. All Payments should be made at any UNITED BANK FOR AFRICA Plc (UBA), with online facilities into ACCOUNT NO. 00900310000212, ACCOUNT NAME - “WEST AFRICAN COLLEGE OF SURGEONS (EXAMS)”. Candidates must indicate their names in the Teller Column ‘Paid By’ and also indicate their Faculty & Part of examination on the Teller. Candidates must indicate their names in the Teller Column ‘Paid By’ and also indicate their Faculty & Part of examination on the Teller.
- c. Copies of relevant professional certificates (see items 7, 8, 9 below), copy of Log Book s(Parts I & II), Case Book/Dissertation – (Parts I & II), two passport size photographs, copy of Bank Teller indicating – Name - Part & Faculty and Three self addressed stamped envelopes must be attached.
- d. Deferment after submission of applications no longer acceptable.
- e. Examination scripts are the property of the College.

**SPECIFIC DETAILS**

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

	<b>Faculties</b>		<b>Sub-Speciality</b> ( <i>where applicable</i> ):
1.	<b>ANAESTHESIA</b>		
2.	<b>DENTAL SURGERY</b>		
3.	<b>OBSTETRICS &amp; GYNAECOLOGY</b>		
4.	<b>OPHTHALMOLOGY</b>		
5.	<b>OTORHINOLARYNGOLOGY</b>		
6	<b>RADIOLOGY</b>		
7.	<b>SURGERY</b>		

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

13. 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.*

..... <i>Name</i>	..... <i>Signature</i>	..... <i>Date</i>
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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.*

..... <i>Name</i>	..... <i>Signature</i>	..... <i>Date</i>
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# WEST AFRICAN COLLEGE OF SURGEONS

## CERTIFICATE OF TRAINING

FORM C

NAME: .....

PRESENT POSTAL ADDRESS: .....

FACULTY/SPECIALITY ..... TRAINING INSTITUTION:.....

	Posting/Appointment	Date Commenced	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).