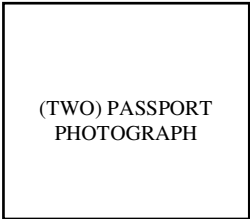


WEST AFRICAN COLLEGE OF SURGEONS
6, Taylor Drive, Off Edmund Crescent,
P. M. B. 1067, Yaba.
Lagos, Nigeria



FORM OF ENTRY TO COLLEGE EXAMINATIONS

Instructions & Notices

- a. *This form, when fully completed, must be returned to the Secretary General, WACS, as early as possible at the address above but not later than the advertised closing date.*
- b. *All Payments should be made at any UNITED BANK FOR AFRICA Plc (UBA), with online facilities to 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 Faculty, & Part on the Teller.*
- c. *Copies of relevant professional certificates (see items 8, 9, 10 below) and two passport size photographs with THREE self addressed (stamped) Envelope 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.*

GENERAL INFORMATION

- 1. **Surname** (Block Capitals)
- 2. **Other names:** Block Capitals).....
- 3. **Maiden Name:** (if any)
- 4. **Residential Address:**.....
- 5. **Postal Address** (if different from above)
- 6. **E-mail address** **Telephone No.**
- 7. **Date of Birth:** 7a. **Sex:**
- 8. **Nationality:**

- 9. Professional and University Qualifications: Name of University/ College: Date:
 -
 -

10. Date of full registration with National Medical Council/Board

11. Date of Discharge from NYSC Programme or Rural Service as applicable:

- 12. Post-registration Appointments:
 -
 -

SPECIFIC INFORMATION

13. College Faculty to which application is being made. (Mark X in the appropriate box).

WACS Faculties	
<input type="checkbox"/>	ANAESTHESIA
<input type="checkbox"/>	DENTAL SURGERY
<input type="checkbox"/>	OBSTETRICS & GYNAECOLOGY
<input type="checkbox"/>	OPHTHALMOLOGY
<input type="checkbox"/>	OTORHINOLARYNGOLOGY
<input type="checkbox"/>	RADIOLOGY
<input type="checkbox"/>	SURGERY

14. Date of entry to an Accredited Training Programme:

15. Name of Institution:

16. Date of Examination applied for

17. **Preferred Examination Centre:** (Tick [√] as appropriate):

<input type="checkbox"/>	ABUJA	<input type="checkbox"/>	IBADAN	<input type="checkbox"/>	FREETOWN
<input type="checkbox"/>	ACCRA	<input type="checkbox"/>	ENUGU		

WEST AFRICAN COLLEGE OF SURGEONS



**APPLICATION FOR ADMISSION TO
PRIMARY FELLOWSHIP EXAMINATIONS**

18. Previous attempts at the Primary Fellowship Examination?

	Date
Nil <input type="checkbox"/>	1. <input type="text"/>
	2. <input type="text"/>
	3. <input type="text"/>
	4. <input type="text"/>
	5. <input type="text"/>

19. 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:

CERTIFICATION

20. **FOR THE CANDIDATE'S CURRENT HEAD OF DEPARTMENT or SUPERVISING CONSULTANT**

I certify that the candidate has satisfactorily worked in my Department/Unit from to

Signature:..... Date:

Qualifications:

Full Name:

Address:

.....

<u>For Office Use Only</u>	<u>Action By</u>	<u>Signature</u>
Date Application received	Exam. Officer
Date Application checked.....	Accountant
Fee Paid.....	Faculty Officer
Exam. No.....	Secretary General

FOR OFFICIAL USE

EXAMINATION DATE

FEE PAID:

TELLER NO/DATE

RECEIPT NO.:

EXAMINATION NO. :

EXAMINATION CENTRE:

NB: PLEASE TICK THE PREFERRED CENTRE FOR THE EXAMINATION: ITEM 17.

(Changing of Centre after submission of form will not be ENTERTAINED)