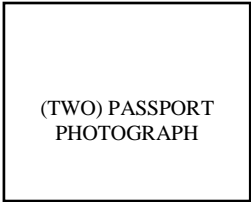


WEST AFRICAN COLLEGE OF SURGEONS
6, Taylor Drive, Off Edmund Crescent,
P. M. B. 1067, Yaba,
Lagos, Nigeria



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. 1014816816, ACCOUNT NAME - "WEST AFRICAN COLLEGE OF SURGEONS" Candidates must indicate their names in the Teller Column 'Paid By' and also indicate Faculty, & Part on the Teller.*

c. *For Candidates sitting exams in Accra Ghana. Payments should be made to Mr. Abraham Okletey in WAPMC liason Office at UGMS, Korle Bu, Accra, Ghana).*

d. *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.*

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

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

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"/>	OPHTHALMOLOGY
<input type="checkbox"/>	OTORHINOLARYNGOLOGY

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"/>	ACCRA
<input type="checkbox"/>	IBADAN

18. Previous attempts at the Diploma Examination?

Nil

	Date
1.	
2.	
3.	
4.	
5.	

19. Candidate's Signature 19a. Date:

20. 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.

CERTIFICATION

21. **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	Clerical Officer
Date Application checked.....	Exam. Officer
Fee Paid.....	Accountant
Exam. No.....	Exam. Officer
Admission letter Issued on.....	Faculty Officer
Result.....	Secretary General

WEST AFRICAN COLLEGE OF SURGEONS



APPLICATION FOR ADMISSION TO DIPLOMA EXAMINATIONS

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)