

18. Previous attempts at the Primary Fellowship Examination?

Date	
1	
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Nil

19. Candidate's Signature ..... 19a. 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:** .....

.....

FOR OFFICE USE ONLY	ACTION BY	SIGNATURE
Date Application received .....	Clerical Officer	.....
Date Application checked .....	Examination Officer	.....
Fees paid .....	Accountant	.....
Exam. No. ....	Examination Officer	.....
Admission letter Issued on .....	Examination Officer	.....
Result .....	Secretary General	.....

**WEST AFRICAN COLLEGE OF SURGEONS**



**APPLICATION FOR PRIMARY FELLOWSHIP EXAMINATIONS**

**FOR OFFICIAL USE**

EXAMINATION DATE .....

FEE PAID: .....

TELLER NO/DATE.....

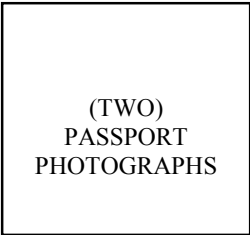
RECEIPT NO.: .....

EXAMINATION NO. : .....

EXAMINATION CENTRE: .....

**WEST AFRICAN COLLEGE OF SURGEONS**

6, Taylor Drive, Off Edmund Crescent,  
P. M. B. 1067, Yaba.  
Lagos



**FORM OF ENTRY TO COLLEGE EXAMINATIONS**

**Instructions and 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 FIRST BANK NIGERIA Plc Branch with ONLINE facilities in Nigeria. Candidates should pay into Account No. 3162010038711 in the name of WEST AFRICAN COLLEGE OF SURGEONS Candidates must indicate their names in the Teller Column 'Paid By' and also indicate their Faculty & Part. The duplicate Teller will be submitted along with the Examination Application Form to the College Secretariat.*

c. *Copies of relevant professional certificates (see items 9, 10, 11 below), 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 cases of application for refund are no longer acceptable.*

**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:** .....      6a. **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 Relevant National Medical Council** .....
11. **Date of Discharge from NYSC Programme or Rural Service as applicable:** .....
12. **Post-registration Appointments:** .....

**SPECIFIC INFORMATION**

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

	ANAESTHESIA
	DENTAL SURGERY
	OBSTETRICS & GYNAECOLOGY
	OPHTHALMOLOGY
	OTORHINOLARYNGOLOGY
	RADIOLOGY
	SURGERY

14. **Date of entry to an Accredited Training Programme:** .....
15. **Name of Institution:** .....
16. **Date of Examination applied for** .....
17. **Preferred Examination Centre** (Circle as appropriate): **Ibadan / Accra / Banjul.**