

WEST AFRICAN COLLEGE OF SURGEONS

6, TAYLOR DRIVE OFF EDMUND CRESCENT MEDICAL COMPOUND

PMB 1067, YABA LAGOS

TEL: 01-8980038, 01-7616563, 01-7737019

APPLICATION FOR REGISTRATION AS A SURGEON IN TRAINING

This Form should be accompanied by the following:

- a. Passport Photograph
- b. Copies of relevant certificates
- c. Bank Teller of **Twenty Thousand Naira (N20,000)** or its equivalent in favour of **West African College of Surgeons in UBA LUTH Branch, A/C No 00900110000504**

N.B. A copy of the College Prospectus should be purchased upon registration

1. FULL NAME: _____
(Surname First)
2. DATE OF BIRTH: _____
3. CURRENT POSTAL ADDRESS: _____

4. TELEPHONE NO (Mobile) _____
(Home) _____
5. E-mail Address: _____
5. NAME OF INSTITUTION WITH FULL ADDRESS _____

6. QUALIFICATIONS WITH DATE AND NAMES OF AWARDING INSTITUTIONS

7. DATE OF FULL REGISTRATION AS A MEDICAL PRACTITIONER

8. SPECIALTY/FACULTY _____
9. APPOINTMENTS SINCE QUALIFICATION (give Date)

10. POSTGRADUATE EXAMINATIONS PASSED (Give Date)

11. DATE STARTED POSTGRADUATE TRAINING: _____

I certify that the above information is correct

NAME

SIGNATURE AND DATE

SECTION B:

(To be filled in by the Applicant's Head of Department)

I certify that the above information is correct.

Name: _____

Qualification: _____

Contact Address: _____

Telephone No (Mobile) _____

(e-mail) _____

Signature, Dates and Stamp _____

SECTION C

(To be filled by a Fellow of the West African College of Surgeons (Other than the Head of Department))

I certify that Dr. _____

Has the professional, ethical standards required of a Fellow of the West African College of Surgeons.

Name: _____

Contact Address: _____

Telephone No (Mobile) _____

(E-mail) _____

Signature & Dates _____