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

(TWO) PASSPORT PHOTOGRAPH

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. ***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 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**: ..... . **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	
	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:** (*Tick* [√] *as appropriate*):

	ABUJA
	ACCRA

	IBADAN
	ENUGU

	KUMASI

18. Previous attempts at the Primary Fellowship Examination?

	Date

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: .....

.....

For Office Use Only	***Action By***	***Signature***
Date Application received …….	Exam. Officer	…….
Date Application checked……..	Accountant	……
Fee Paid……..	Faculty Officer	……
Exam. No……	Secretary General	……

WEST AFRICAN COLLEGE OF SURGEONS

APPLICATION FOR ADMISSION TO PRIMARY FELLOWSHIP 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)