## **WEST AFRICAN COLLEGE OF SURGEONS**



## AUTHENTICATION FORM FOR MEMBERSHIP/PART I & FELLOWSHIP(PART II) EXAMINATIONS

FACULTY / SPECIALTY	PECIFIC DETAILS  aculty Examination for which candidate wishes to appear (Please Mark X in the appropriate    Faculties	LTS		N NAME: (if any)		Training Institu	tion
Faculty Examination for which candidate wishes to appear (Please Mark X in the appropriate Box   Sub-Speciality (where applicable): (X)    1. ANAESTHESIA	Faculties  Faculties  Tick (X)  Sub-Speciality (where applicable):  (X)  1. ANAESTHESIA  2. DENTAL SURGERY  3. OBSTETRICS & GYNAECOLOGY  4. ORTHOPAEDICS  5. OPHTHALMOLOGY  6. OTORHINOLARYNGOLOGY  7. RADIOLOGY  8. SURGERY  mature of Candidate (with date):  declare that the statements made in this application are to the best of my knowledge correct and correct that any statement found to be false may render me liable to disqualification from the examinancions.  Candidate's Signature  Date:  Same of Head of Department:  Signature of Head of Department (with date):  RECOMMENDATION  mendations by Two Fellows in good standing with the College at least ONE of whom must be a Fel-Faculty:  I hereby certify that		CULT	TY / SPECIALTY		PART	
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## CERTIFICATE OF TRAINING



ACULTY/SPECIALITY TRAINING INSTITUTION:									
	Posting/Appointment	Date Commenced (dd/mm/yyyy)	Date Completed (dd/mm/yyyy)	Duration of Training	Name and Signature of Supervising Consultant (with dates)	Remarks			
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NOTES:

- . It is the duty of and responsibility of the candidate/trainee to acquaint himself/herself of the current rules on the type, duration and minimum number of rotations required before admission into any part of the Fellowship examinations in his/her speciality.
- 2. Where candidate/trainee trains in more than one institution, a certificate of training must be obtained from each Institution.
- 3. Photocopies of certificates previously submitted to the College should be appended to newly obtained certificate(s).