WEST AFRICAN COLLEGE OF SURGEONS

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

1. **SURNAME** (*in **BLOCK** letters*) ....

2. **OTHER NAMES**: ....

3. **MAIDEN NAME:** (*if any*) ..... **Training Institution**.....

4. **FACULTY / SPECIALTY** …… **PART** ……..

5. **SPECIFIC DETAILS**

Faculty Examination for which candidate wishes to appear (*Please Mark X in the appropriate Box*)

	Faculties	Tick (X)	Sub-Speciality (*where applicable*):
1.	**ANAESTHESIA**		
2.	**DENTAL SURGERY**		
3.	**OBSTETRICS & GYNAECOLOGY**		
4.	**ORTHOPAEDICS**		
5.	**OPHTHALMOLOGY**		
6.	**OTORHINOLARYNGOLOGY**		
7.	**RADIOLOGY**		
8.	**SURGERY**		

6. Signature of Candidate *(with date)*: .....

7. *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: .....

8. Name of Head of Department: .....

9. Signature of Head of Department *(with date)*: .....

RECOMMENDATION

Recommendations by Two **Fellows** in good standing with the College at least **ONE** of whom must be a Fellow of the relevant Faculty:

A. *I hereby certify that ..... is personally known to me and I consider him/her to be in every way suitable for admission into the Fellowship examination of the College*.

....
Name *Signature* *Date*

B. *I hereby certify that ..... is personally known to me and I consider him/her to be in every way suitable for admission into the Fellowship examination of the College*.

....
Name *Signature* *Date*

CERTIFICATE OF TRAINING

NAME: …… ……

PRESENT ADDRESS: …… ……**PART** ……

FACULTY/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
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

I certify that the information given above is correct to the best of my knowledge.

…… …… ……

CANDIDATE (*Signature & Date*)

HEAD OF DEPARTMENT (*Signature, name, date and Official Stamp*)

HEAD OF TRAINING INSTITUTION/CHIEF MEDICAL DIRECTOR (*Signature, Name, Date and Official Stamp*)

NOTES:

1. *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).*