WEST AFRICAN COLLEGE OF SURGEONS

4, HARVEY ROAD, YABA, LAGOS

Affix a Passport Photograph

APPLICATION FOR REGISTRATION AS A SURGEON-IN-TRAINING

1. FULL NAME:_____
   (Surname First)

2. GENDER:_____

3. DATE OF BIRTH: _____

4. CURRENT ADDRESS: _____

5. TELEPHONE NO : _____

6. E-mail Address**:**_____

7. NAME OF INSTITUTION WITH FULL ADDRESS_____
   _____

8. QUALIFICATIONS WITH DATES AND NAMES OF AWARDING INSTITUTIONS
   _____
   _____

9. DATE OF FULL REGISTRATION AS A MEDICAL PRACTITIONER
   _____

10. SPECIALTY/FACULTY_____

11. APPOINTMENTS SINCE QUALIFICATION (give Date)
    _____
    _____

12. POSTGRADUATE EXAMINATIONS PASSED (Give Date)

_____

_____

13. COMMENCEMENT DATE OF POSTGRADUATE TRAINING:_____

_____*(Attach letter of Appointment)*

I certify that the above information is correct.

_____ _____

NAME SIGNATURE AND DATE

Fellows/HOD, FWACS must be in good financial standing with the College.

SECTION B:

(To be completed 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 completed by a Fellow of the *West African College of Surgeons in good financial standing with the College).*

I certify that Dr. _____
Has the professional and ethical standards required of a Fellow of the West African College of Surgeons.

Name: _____

Qualification:_____

Contact Address:_____

Dept:_____

Telephone No (Mobile) _____

(E-mail)_____

Signature & Dates _____