FORM A

GHANA COLLEGE OF PHYSICIANS AND SURGEONS

APPLICATION FOR PRIMARY EXAMINATIONS

FOR OFFICE USE ONLY

NAME:...

AMOUNT PAID:...**RECEIPT. NO.:**...

EXAMINATION DATE:..**INDEX NO.:**...

FACULTY :..

GHANA COLLEGE OF PHYSICIANS AND SURGEONS
P. O. Box MB 429
Ministries-Accra
Ghana, West Africa
Tel: +233-0302-238650/238703 Cell: 0243-690073
E-mail: ghcollege@vodafone.com.gh

Instructions and notices

a. This form, when fully completed, must be returned to the **RECTOR, GHANA COLLEGE OF PHYSICIANS AND SURGEONS** as early as possible, but **not later than the advertised closing date**.

b. The application must be accompanied by a pay in slip from any branch of Ecobank. Monies must be paid into the following account: Ecobank, Ridge Branch, Ghana College of Physicians and Surgeons Donor Pool Fund, number **0010 1344 0464 8401.** It is the duty of the candidate (foreign) to find out the equivalent of the Examination Fee in his/her home currency at the time of submission of the application.

c. Copies the following certificates: MB ChB, B.Sc., Full registration with Medical and Dental Council (MDC), current Retention certificate with the (MDC) or evidence of payment, one self addressed envelope with stamp and one passport sized picture.

d. Application for deferment or withdrawal will **NOT** be considered if received **later than eight (8) weeks before the date of the examination**. A 40% administrative surcharge is chargeable for all refunds and deferment.

e. Examination scripts are the property of the College and shall normally be destroyed **two (2) years** after the examination.

GENERAL INFORMATION

1. **SURNAME** (Block Letters): ....
2. **OTHER NAMES**: ....
3. **MAIDEN NAME** (if applicable):..
4. **POSTAL ADDRESS:** ....

   ....
5. **CURRENT STATION:**..
6. **DATE OF BIRTH**: .... AGE:..................................**SEX**:....................................
7. **NATIONALITY**: ....
8. **E-MAIL ADDRESS (should be eligible)**: ....
9. **TEL. NO.** : ....
10.

Professional/University Qualification	Name of University/Institution	Date

11. Medical & Dental Council (MDC) Registration number..

12. Post-registration appointments with dates:

    a)...

    b)...

    c)...

    d)...

SPECIFIC DETAILS

13. Constituent College and Faculty to which application is being made. (Mark **X** in the appropriate box)

Ghana College of Physicians	Ghana College of Surgeons
Internal Medicine	Anaesthesia
Laboratory Medicine	Dental Surgery
Child Health	Obstetrics & Gynaecology
Psychiatry	Ophthalmology
Family Medicine	Otorhinolaryngology
Radiotherapy	General Surgery
Radiology	Emergency Medicine

14. Have you commenced any post-graduate training? Yes / No

15. If yes, indicate the date you commenced ....

16. Name of Institution ....

17. Training Centre ....

18. Any previous attempts at Primary Examinations of this College? Yes / No

19. If 'yes', please indicate date(s):

    a) ....

    b)...

    c)...

    d)...

20. Signature of applicant...Date ....

CERTIFICATION

21. FOR THE APPLICANT' S CURRENT HEAD OF DEPARTMENT or SUPERVISING CONSULTANT

I certify that the applicant has satisfactorily worked in my department/unit

From..to:...

Signature:...Date:..

Full name: ....

Address & official stamp: ....

....

....