

GHANA COLLEGE OF PHYSICIANS AND SURGEONS

GHANA COLLEGE OF
PHYSICIANS & 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:

.....

.....