

*FORM A*

# GHANA COLLEGE OF PHYSICIANS AND SURGEONS

GHANA COLLEGE OF  
PHYSICIANS & SURGEONS



## APPLICATION FOR PART I (MEMBERSHIP) EXAMINATIONS

**FOR OFFICE USE ONLY**

<p><b>NAME:</b>.....</p> <p><b>AMOUNT PAID:</b>.....<b>RECEIPT. NO.:</b>.....</p> <p><b>EXAMINATION DATE:</b>.....<b>INDEX NO.:</b>.....</p> <p><b>FACULTY :</b>.....</p>
---

**Note:** This form is for those already in training.

**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](mailto: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 six (6) weeks before the date of the examination.** A 25% 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.

<b>Professional/University Qualification</b>	<b>Name of University/Institution</b>	<b>Date</b>

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

<u>Part I Membership) for those in training</u>
Laboratory Medicine
Radiotherapy
Radiology 1A
Radiology 1B

<u>Part I Membership) for those in training</u>
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: .....

.....

.....