Affix passport size photograph here

GHANA COLLEGE OF PHYSICIANS AND SURGEONS

APPLICATION FORM FOR ADMISSION TO RESIDENCY PROGRAMMES (FELLOWSHIP)

IMPORTANT: APPLICANTS ARE REQUESTED TO SEND **THREE COMPLETED SETS OF FORMS INCLUDING ATTACHMENTS** TO: THE RECTOR, GHANA COLLEGE OF PHYSICIANS AND SURGEONS, P. O. BOX MB 429, ACCRA

ENCLOSURES:

(i) Registration fee of **Six hundred Ghana Cedis (¢600.00)** must be paid into the Ghana College of Physicians and Surgeons Donor Pool Fund Account Number **0010 1344 0464 8401, ECOBANK GHANA LTD., RIDGE WEST BRANCH** (swift Code: ECOCGHAC). Payment can also be done at any GT Bank branch through GCPS Pay. In addition, payment can be done electronically online using VISA or Mastercard on the College website by clicking GCPSPAY.

(ii) **Three** copies of GCPS Membership certificate and current registration (**Retention**) with the Medical and Dental Council of Ghana.

(iii) One self addressed stamped envelope.

(iv) Three recent **standard** passport size photographs.

(v) Candidates must be in **good standing** with the College.

1. Surname ……

2. Other Names (in full) ……

3. Former name(s)……

4. Date of Birth(dd/mm/yyyy) …… 5. Nationality……

6. Marital Status…… 7. No. of Children……

8. (a) Address to which all communications relating to this application should be sent:

……

……

(b) Tel. No…… E-mail……

Fax……

(Any change of address must be communicated at once to the Rector, Ghana College of Physicians and Surgeons)

9. Name and Address of next of kin……

……

10. Tel. No. of Next of Kin…… 11. Relationship of next of kin to applicant: ……

FOR OFFICE USE ONLY	
Application Fee……	**Date submitted: ……**
Received and acknowledged by: ……	**Signature: ……**

13. Any other qualifications apart from Membership of GCPS: ……

……..

14. Have you been on any form of sponsorship? Yes: …… No: ……

15. If you answered "yes" above, give details of the sponsorship(s):

No.	Name and Address of sponsor	From	To	Programme for which sponsored

EMPLOYMENT RECORD

16. Past and present employment with dates. (Start with the latest)

No.	Name and Address of Institution	From	To

17. Name and address of current employer: ……

……..

19. **CHOICE OF TRAINING CENTRE**

1st Choice ……

2nd Choice ……

3rd Choice ……

SPONSORSHIP FOR RESIDENCY TRAINING

20. Give details of sponsorship during the residency training:

a) MoH: ……

b) GHS Agency: ……

b) Self Sponsoring: ……

c) Other (specify): ……

21. Name and address of the Head/Medical Director/Chief Executive Officer of your ***CURRENT*** work place.

Name…….

Address……

Tel. No…….

Signature: ……

22. **ENDORSEMENT BY DISTRICT DIRECTOR OF HEALTH (Applicable to MOH/GHS agencies)**

Name…….

Address……

Tel. No…….

Signature: ……

Date…… ……..

Signature of Applicant