



Affix passport size photograph here

GHANA COLLEGE OF PHYSICIANS AND SURGEONS
APPLICATION FORM FOR ADMISSION TO RESIDENCY PROGRAMMES (MEMBERSHIP)

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 MB ChB certificate. Three copies of Full Registration (MDC) certificate. Three copies of current Retention OR evidence of payment with the Medical and Dental Council of your country. Three copies of Primary examination pass letter.
(iii) One self addressed envelope affix with a postage stamp.
(iv) Three recent standard passport size photographs.

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:

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.....

(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:

Table with 2 columns: Application Fee, Date submitted, Received and acknowledged by, Signature. Header: FOR OFFICE USE ONLY

EDUCATIONAL INFORMATION

12. Universities attended stating Degree(s) obtained, giving class/divisions or other details (where applicable), dates and subject(s).

No.	Name and Address of University/Institution	From	To	Qualification/Degree obtained

13. Any other qualifications:

.....

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:

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CHOICE OF SPECIALTY

18. (a) Specialty in which applicant proposes to do residency.....
.....
(b) Reasons for choosing Specialty.....
.....
.....

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