

GHANA COLLEGE OF PHYSICIANS AND SURGEONS

APPLICATION FORM FOR ADMISSION TO FELLOWSHIP

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IMPORTANT: APPLICANTS ARE REQUESTED TO SEND ONE COMPLETED FORM TO:

THE RECTOR
GHANA COLLEGE OF
PHYSICIANS AND SURGEONS
P.O. BOX MB 429 – MINISTRIES
ACCRA

(You may continue on extra sheets where necessary)

ENCLOSURES WITH THE FOLLOWING

- (i) Application Fee of US\$150 or equivalent in cedis (Non-refundable). Cash or Bankers' Draft to be made payable to the Ghana College of Physicians and Surgeons.
- (ii) Two recent passport size photographs.
- (iii) 1 Copy of Curriculum Vitae.
- (iv) Evidence of your qualifications (certified true copies only).
- (v) Evidence of 'good standing' with the applicants regulatory board in country of practice

APPLYING TO THE FACULTY OF (Please See Page 4)

- 1. Surname Dr./Prof.
 - 2. Other Names (in full).....
 - 3. Former name (if any).....
 - 4. Date of Birth.....
 - 5. Nationality.....
 - 6. Address:
 - a) Residential.....
 - b) Postal.....
 - c) E-mail
 - d) Telephone.....
 - e) Fax (if any).....
- (Any change of address must be notified at once to the Rector, Ghana College of Physicians and Surgeons)*

Name and address of next of kin: (a) Name.....

(b) Postal

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(c) Residential.....

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(d) Tel. No.

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8. Relationship of next of kin to applicant.....

9. Universities attended stating Degree(s) obtained, giving class/divisions or other details and dates:

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10. Other academic qualifications.....

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11. Particulars of past and present employment (indicate present place of work and address)

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12. Membership of Professional Bodies etc.

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13. Research Interests.

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14. Publications, with references (*please continue on an extra sheet and attached one publication*)

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15. Give reasons, in writing, why you would like to join the College (*please use an extra sheet*)

SPONSORS

16. Names and addresses of three Fellows of this College, two of whom must belong to the Faculty you wish to join. Written recommendations should be sent directly to the College.

a) Name.....
Faculty.....
Address.....
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Tel No:..... Signature.....

b) Name.....
Faculty.....
Address.....
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.....
Tel No:..... Signature:.....

c) Name.....
Faculty.....
Address.....
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.....
Tel No:..... Signature:.....

Date.....
.....
Signature of Applicant

FACULTIES OF THE GHANA COLLEGE OF PHYSICIANS AND SURGEONS

Anaesthesia and Intensive Care
Dental Surgery and Sub-Specialties
Emergency Medicine
Family Medicine

Laboratory Medicine
Obstetrics and Gynaecology
Paediatrics & Child Health
Psychiatry

General and Specialized Surgery
Internal Medicine

Public Health
Radiology, Oncology, Radiotherapy

FOR OFFICE USE ONLY

Application Fee.....

Bank Draft/P.O. No/Cash

Received and acknowledged.....

Date:.....