NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA

Km 26, Lagos Badagry Expressway, P.M.B. 2003 Ijanikin, Lagos
TEL. 01-2913110, 01-3422586, website: www.npmcn.edu.ng

APPLICANT'S PASSPORT PHOTO

APPLICATION FORM FOR DIPLOMA EXAMINATION

IN THE FACULTY OF ……..

1. NAME IN FULL ……
   (Surname) (Other names)
2. MAIDEN NAME OR PREVIOUS NAME (IF ANY)…….
3. CONTACT ADDRESS…….
4. TELEPHONE NO……..
5. E-MAIL ADDRESS……
6. DATE OF BIRTH…….. 7. SEX……..
8. STATE OF ORIGIN…… 9. STATE OF DOMICILE……
10. LOCATION OF INSTITUTION CANDIDATE REGISTERED ……..
11. REGISTRATION NUMBER AT THE INSTITUTION (TRAINING CENTRE) ……..
12. **GENERAL INFORMATION:**
    (a) Each candidate must complete this form fully and correctly and forward it together with the following:
        (i) 3 passport photographs with name and Faculty written at the back
        (ii) 3 stamped self-addressed envelopes
        (iii) All other necessary documents to the College Registrar before the closing date
    (b) Applications submitted after the closing date or incorrectly/incompletely filled or not accompanied with the required documents will be rejected and a penalty will be exacted.
    (c) You are advised to buy from the College, a copy of the Faculty's Guidelines to Candidates' as well as Examination Regulations before attempting to complete this form.
    (d) Where alternative exists, delete as appropriate.

Please return the completed form to the College Registrar at the above address

SECTION A

1. Photocopies of the following documents are herewith enclosed. (tick Box as appropriate)
   (i) Evidence of change of name (If applicable) ☐
   (ii) Basic Medical/Dental Degree Certificate ☐
   (iii) Certificate of Full Registration with the Nigerian Medical and Dental Council of Nigeria ☐
   MDCN Full Registration Number……
   (iv) Current Practicing License or Receipt ☐
   (v) N.Y.S.C. Discharge Certificate or Exemption ☐
   (vi) Letter of Admission into the Diploma Programme ☐
   (vii) College Receipt(s) for Associate Diplomate ☐

   Year of Subscription as Associate Diplomate ……

   (viii) Certificate of Training from each Institution/Number of Institutions involved…… ☐
   (ix) Clinical Log Book ☐

SECTION B

2. Basic Professional Education:

MEDICAL/DENTAL SCHOOL	DEGREE	DATES

3. Post-Registration Appointments:

APPOINTMENTS	HOSPITAL/HEALTH FACILITY	SUPERVISING CONSULTANTS (IF ANY)	DATES

4. List the rotations you have done during your training as Associate Diplomate in approved Institutions.

DATES	POSITION HELD	DEPT/UNIT	SUPERVISING CONSULTANTS NAME, SIGNATURE & DATE	HOSPITAL

5. Have you attached a copy of your clinical log book? ☐ Yes or No

6. List any course of training you have attended other than the routine programmes of your training institution during your Diploma training.

COURSE	DURATION	ORGANISING INSTITUTION
a.		
b.		
c.		
d.		
e.		

7. (a) Have you taken the Diploma Examination before?

   (b) If so, how many times?.....

SECTION C

DECLARATION

8. I declare that the statements made in this application are to the best of my knowledge correct and complete and I accept that any statement found to be false may render me liable to disqualification from the examination.

   Dated this…….. Day of …… 20……

   …….
   Signature of Applicant

SECTION D

To be completed by the current Head of Department in the current Training Institution or place of employment.
A self-employed candidate must have this section completed by his/her last Head of Department or Head of Institution/Organization.

9. I certify that all the particulars stated above in respect of this candidate are to the best of my knowledge correct.

10. I certify that he/she has been in the Diploma training programme/employment of this Institution continuously since…… during which time he/she has performed his/her duties satisfactorily.
    (a) If he/she is not in your Diploma training Programme, but only in your employment, please state why……
    (b) Where did he/she undergo his Diploma training?
    ……
    (c) Have you seen his/her Certificate of Training?……

NAME……

PROFESSIONAL STATUS……

DEPARTMENT……

NAME OF INSTITUTION……

……

…….. ……..

Signature Date

Official Stamp

VERIFICATION BY ZONAL COORDINATOR (*WHERE APPLICABLE*)

I confirm that Dr. ……registered for the Diploma Programme and participated in the prerequisite lectures and practicals in this ……Centre. He may therefore be enrolled for the College examinations.

NAME: ……..

SIGNATURE/DATE: ……

SECTION E

To be completed by a Fellow of the National Postgraduate Medical College of Nigeria in the Faculty of the applicant.

11. I pledge my honour as a Fellow of the College and attest that I have knowledge of the character and integrity of Dr……..and I am willing to recommend his/her admission into my Faculty as a Diplomate, subject to a satisfactory completion of the requirements for such admission:
    (i) NAME……
    (ii) FACULTY……

(iii) ADDRESS……

(iv) SIGNATURE……..

(v) DATE OF FELLOWSHIP…….

SECTION F

FOR OFFICE USE ONLY

Part A (for Examination Officer)

Date of Receipt of Application……

Examination Fee…….RRR No…….
Receipt No…….
Form and Credentials checked and passed by…….

…….. ……
Name Signature

…….
Date

PART B (for Faculty Board Secretary only)

I certify that Dr…… is/is not eligible to sit for the Diploma Examination of the Faculty of ……..

Other comments (including reasons for non-eligibility):
……
……
……
……..

Name of Faculty Board Secretary……

…….. ……
Signature Date

PART C (For Examination Officer)

Examination Number…….

Date Sent…….

College Stamp……

Signature …… ……
Examination Officer Date