NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA

Km 26, Lagos-Badagry Expressway, P.M.B. 2003 Ijanikin, Lagos
Tel. 01-2913110, 01-2904523 website: www.npmcn.edu.ng
Email: registrar@npmcn.edu.ng; info@npmcn.edu.ng

REGISTRATION OF ASSOCIATE FELLOWS

IN THE FACULTY OF----------

A. PERSONAL DETAILS

NAME.....

Surname Middle name First name

HOME ADDRESS.....

.....

PROFESSIONAL/INSTITUTION ADDRESS.....

…….....

…….....

PREFERRED POSTAL ADDRESS.....

……..

……..

TELEPHONE NO.....

EMAIL ADDRESS.....

DATE OF BIRTH..... SEX.....MARITAL STATUS ……..…….

SPOUSE'S NAME.....

SPOUSE'S ADDRESS.....

……..……..

NEXT OF KIN (IF DIFFERENT FROM SPOUSE).....

ADDRESS OF NEXT OF KIN.....

……..…….....

B. BASIC MEDICAL EDUCATION

University/Medical School..... Dates.....

Basic Medical Degree..... Dates.....

C. PRIMARY OF NPMCN Yes ☐ No ☐

D. EXEMPTION FROM NPMCN PRIMARY Yes ☐ No ☐

E. EQUIVALENT QUALIFICATION TO NPMCN PRIMARY

…….

DATE OF PRIMARY OR EXEMPTION OR EQUIVALENT QUALIFICATION:

……

F. PRE-REGISTRATION APPOINTMENTS

Dates	Hospital	Department	Consultant
1.			
2.			
3.			
4.			

G. FULL REGISTRATION WITH MEDICAL & DENTAL COUNCIL

1. Date of full Registration: .....

2. Number on full Registration Certificate.....

H. YOUTH CORPS YEAR

	Dates	Institution	Supervising Consultant
Primary Posting			
Community Project			

I. POST REGISTRATION EXPERIENCE IN CHRONOLOGICAL ORDER

Please asterisk those not recognised for Part I.

S/N	Dates	Institution	Specialty	Supervising Consultant
1				
2.				

3.				
4.				
5.				
6.				
7.				
8.				

J. FELLOWSHIP EXAMINATION STATUS

S/N	Dates	Faculty	Level of Examination	Institution	Result

K. INSITUTIONAL BASE FOR RESIDENCY TRAINING

- Name of Institution.....
- Date Accredited…..... Accreditation Status: Full/Partial
- Date of Candidate's First Appointment.....
- Status of Candidate on First Appointment….....
- Current Status of Candidate.....

RECOGNISED POSTINGS COMPLETED:

Duration	Dates	Posting	Supervising Consultant

L. PAYMENT OF ASSOCIATE FELLOWS REGISTRATION FEES

1. You are required to pay the sum of thirty thousand naira (₦30,000.00) only as Admission fee for Associate Fellow Registration using the REMITA payment platform. Check College website (www.npmcn.edu.ng) for details of payment through REMITA website (www.remita.net)
2. You will also pay Associate Fellows Annual subscription dues from the year you started training till date, the annual subscription is ten thousand naira (₦10,000.00) per year into Zenith Bank Plc, Aguda Branch Account No. 1010778138 and sort code No. 057150437. Payment is expected to be made before 31st of January every year and payment made after 31st of January attracts 100% penalty.
3. The evidence of payment of the above admission fee and Annual subscription due are to be attached to the form before forwarding the completed Associate Fellow Application form to the College.

M. CHECKLIST OF DOCUMENTS ATTACHED

(i) Basic Medical/Dental Degree Certificate ☐
(ii) Certificate of Full Registration with the Medical and Dental Council of Nigeria ☐
(iii) NPMCN Primary Notification of Result ☐
(iv) Certificate of Exemption from NPMCN Primary ☐
(v) N.Y.S.C. Discharge Certificate or Exemption ☐
(vi) Evidence of Payment of Associate Fellows Registration Fees ☐

N. ASSOCIATE FELLOWSHIP PLEDGE

I, Dr. .....do pledge and declare as follows:

a. To dedicate myself to the preservation and enhancement of the noble ideals and the ethics of Medicine/Dentistry.

b. To seek to increase my knowledge and skill by continuing self-instruction, by association with specialists of repute and by free exchange of experience and opinion with my teachers and my colleagues at all times and especially in the context of medical care audit.

c. To abide by the rules and regulations of the National Postgraduate Medical College of Nigeria, and ipso facto, by the rules and regulations of the .....*; being a training institution accredited to the said College.

* Insert the name of the hospital institution

.....
Signed

O. ATTESTATION

I do attest to the truth of the information provided above, and have undertaken on behalf of the.....* hospital, to accept **Dr**..... for a.....year Residency Training Programme**.....

Name of Head of Training Department.....

Department of.....

Signature.....Date….....

.....	….....
Name and Signature	*Date*
Chairman, Residency Co-ordinating Committee	
.....	.....
Name and Signature	*Date*
Chief Medical Director/Medical Director	

*Insert the name of the Hospital/Institution

**Insert the name of the discipline in which the resident is being trained, and the corresponding Faculty of the National Postgraduate Medical College of Nigeria