



Application form: COECSA Fellowship Examination

Surname (Last name) _____ First name _____
 Date of birth _____ Sex _____
 Nationality _____ Email _____
 Telephone _____ Address _____

Fellowship training (if any)

| Institution (start with latest) | Period | | Discipline |
|---------------------------------|--------|----|------------|
| | From | To | |
| | | | |
| | | | |

Postgraduate training

| Institution (start with latest) | Period | | Discipline |
|---------------------------------|--------|----|------------|
| | From | To | |
| | | | |
| | | | |

Internship /pre-registration training

| Institution (start with latest) | Period | | Award |
|---------------------------------|--------|----|-------|
| | From | To | |
| | | | |
| | | | |

Basic medical training:

| Institution | Period | | Award |
|-------------|--------|----|-------|
| | From | To | |
| | | | |
| | | | |

Employment record

| Institution (start with latest) | Period | | Position held |
|---------------------------------|--------|----|---------------|
| | From | To | |
| | | | |
| | | | |

Under which regulatory body (council /board) are you currently registered as a Medical practitioner?

Are you registered as a Specialist? Yes/No

If yes, by what regulatory body?

Please note candidates must submit certified copies of their academic and registration certificates in evidence of their eligibility to sit this examination.

I declare that the information given above is true and correct.

.....
 Applicant's name _____ Signature _____

Date

The fee for sitting COECSA Fellowship examination is **USD 140**. Payments should be made by bank transfer to **COECSA** as per details provided in the information pack.

The filled application form must be returned to the COECSA Secretariat, Regent Court, Block A, Suite A7, Argwings Kodhek Road, Hurlingham, P.O Box 4539 – 00506, Nairobi or via email to info@coecea.org and copy to robert@coecea.org