Ceylon College of Physicians

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E-mail: info@ccp.lk

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FELLOWSHIP APPLICATION FORM

I wish to apply for the fellowship of the Ceylon College of Physicians

Please complete using block letters.

PERSONAL INFORMATION

Surname																							
Other names																							

Gender (X)	Male		Female																				
Date of Birth (DD/MM/YYYY)																							
Designation																							

Year of election for the membership	
Academic Qualifications	

I have attached following documents with the application	
Up to date curriculum vitae (CV)	
Certificates	

APPLICANT'S DECLARATION

I certify that I shall neither misuse my fellowship status of the Ceylon College of Physicians, nor act contrary to Sri Lanka Medical Council regulations. I declare that there are no disciplinary or professional misconduct inquiries that have been or are being conducted against me.

Applicant's signature										
	Date									

PROPOSER'S DECLARATION	
I declare that the applicant is known to me and that the information presented herein is accurate. I am not aware of any disciplinaryor professional misconduct inquiries or issues that might affect the applicant's suitability to be a fellow of the College.	
Proposed By	
Designation	
Proposer's signature	Date

SECONDER'S DECLARATION	
I declare that the candidate is known to me and that the information presented herein is accurate. I am not aware of any disciplinaryor professional misconduct inquiries or issues that might affect the applicant's suitability to be a fellow of the College.	
Seconded By	
Designation	
Seconder's signature	Date
Proposer and seconder should be fellows of the Ceylon College of Physicians.	