

EBO-ESOPRS Subspecialty Exam

RECOMMENDATION LETTER

Recommendation Letter for:

Candidate name: _____

Candidate email: _____

To be completed by the main Faculty member responsible for oculoplastic / lacrimal / orbital / aesthetic Fellowship training

Details of Trainer responsible for Candidate's Fellowship training

First name: _____

Last Name: _____

Degrees: _____

Institution: _____

Department: _____

Current position: _____

Email: _____

- 1) Please indicate below your qualifications and expertise in the training of oculoplastic, lacrimal, orbital and aesthetic conditions (OLOA)

- 2) Have you spent a minimum of 5 years devoted mainly to the care of OLOA patients?
 Yes No

- 3) Please indicate approximate % of volume (0 – 100) of patients for each category
 - a. Oculoplastic _____
 - b. Lacrimal _____
 - c. Orbital _____
 - d. Aesthetic _____

- 4) Do you participate in national/international teaching or research activities in the area of OLOA?
 Yes No

If "Yes", please specify

5) Do you actively contribute to a national or international organisation/society providing continuing medical education in OLOA?

Yes No

If "Yes", please specify

6) Did you actively supervise the candidate during their training?

Yes No

7) Did you provide periodical assessments/evaluations to the candidate during their training?

Yes No

8) Was the candidate given written progress reports?

Yes No

9) Have you checked and countersigned (ie validated) the candidate's surgical log-book?

Yes No

If "No", who has?

10) Please indicate those aspects of the ICO Fellowship curriculum the Candidate HAS NOT COVERED during their Fellowship with you ([see p7-18](#))

11) Please indicate any issues relating to the ethical and professional conduct of the candidate while training with you. If NONE, please state "None"

Institution?

12) Is your department of Ophthalmology part of an academic institution?

Yes No

13) Is the Residency programme in Ophthalmology at your institution a minimum of 4 years?

Yes No

If "No", please specify the number of months _____

14) Did the candidate complete their residency in your institution?

Yes No

If "No", please specify where: _____

15) Did the candidate complete a minimum of 12 months Fellowship in OLOA in your institution?

Yes No

Please indicate start and end date

Start date: _____ End date: _____

16) In addition to basic ophthalmic equipment, does your institution provide current diagnostic equipment adequate for Fellowship training in OLOA / or have easy access to this, eg Imaging (X-ray/CT/PET CT/MRI), Ultrasound, Pathology (blood screening tests, histology, Mohs micrographic surgery), multi-disciplinary team review?

Yes No

If "No", please indicate what is lacking

17) Does your institution provide adequate surgical facilities (operating microscope, nasal endoscope etc) for Fellowship training?

Yes No

If "NO", please indicate what is lacking