**EBO-ESOPRS Subspecialty Exam**

**APPLICATION FORM**

**General Candidate Information:**

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile (including country code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Languages spoken:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Qualifications:**

1. Medical School and year qualified
2. Degrees (eg MD, PhD)
3. How many years RESIDENCY in ophthalmology have you completed?
4. Please list in which country (countries) you did your Residency
5. In which UEMS country are you registered as a Specialist in Ophthalmology?

Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of registration body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Registration number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a FEBO diploma (Fellow of European Board of Ophthalmology)?

[ ]  Yes [ ]  No

If “Yes”, year obtained \_\_\_\_\_\_\_\_\_\_

If “No”, what equivalent exam have you passed, and in which year?

Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_

1. After completing your residency, where did you do 12 months minimum Fellowship training? Please indicate all Institutions, dates (time spent in each), and name of person responsible for your Fellowship training. Only list those where you spent **3 months or more.**
	1. Institution name and address

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Dates

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Trainer name and email

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does this institution:**

Provide access to a medical library?

[ ]  Yes [ ]  No

Have facilities for electronic retrieval of medical literature and information from medical databases?

[ ]  Yes [ ]  No

Did the member of the faculty responsible for this Fellowship:

1. actively supervise your training?

[ ]  Yes [ ]  No

1. evaluate you periodically?

[ ]  Yes [ ]  No

1. provide progress reports?

[ ]  Yes [ ]  No

1. validate your surgical log-book?

[ ]  Yes [ ]  No

**Additional copies of question 7 are provided at the end of this form. If you completed your Fellowship at several institutions, please provide these details for each one, otherwise the Application Form will be considered incomplete.**

1. Present appointment
2. Date of appointment
3. Clinical responsibilities
4. Training responsibilities (medical students/residents/Fellows)
5. Participation in National and International meetings IN LAST 3 YEARS

Meeting

Date and place

Oral presentation or Poster

Title

Meeting

Date and place

Oral presentation or Poster

Title

Meeting

Date and place

Oral presentation or Poster

Title

**Please add additional meetings as required**

1. Published articles
2. Scientific research grants
3. Awards
4. Membership of scientific or professional bodies
5. Any other information you wish to add

**Additional copies of Question 7 (to be completed if required)**

After completing your residency, where did you do 12 months minimum Fellowship training? Please indicate all Institutions, dates (time spent in each), and name of person responsible for your Fellowship training. Only list those where you spent **3 months or more.**

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Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Dates

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Trainer name and email

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ]  Yes [ ]  No

1. evaluate you periodically?

[ ]  Yes [ ]  No

1. provide progress reports?

[ ]  Yes [ ]  No

1. validate your surgical log-book?

[ ]  Yes [ ]  No

**Additional copies of Question 7 (to be completed if required)**

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Dates

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Trainer name and email

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Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ]  Yes [ ]  No

1. evaluate you periodically?

[ ]  Yes [ ]  No

1. provide progress reports?

[ ]  Yes [ ]  No

1. validate your surgical log-book?

[ ]  Yes [ ]  No