**EBO-ESOPRS Subspecialty Exam**

**TRAINER RECOMMENDATION FORM**

Recommendation Form 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), including details of any Fellowship undertaken
2. Have you spent a minimum of 5 years devoted mainly to the care of OLOA patients?

[ ]  Yes [ ]  No

1. Please indicate approximate % of volume (0 – 100) of patients for each category
	1. Oculoplastic \_\_\_\_\_\_\_\_\_\_
	2. Lacrimal \_\_\_\_\_\_\_\_\_\_
	3. Orbital \_\_\_\_\_\_\_\_\_\_
	4. Aesthetic \_\_\_\_\_\_\_\_\_\_
2. Do you participate in national/international teaching or research activities in the area of OLOA?

[ ]  Yes [ ]  No

If “Yes”, please specify

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

[ ]  Yes [ ]  No

If “Yes”, please specify

1. Did you actively supervise the candidate during their training?

[ ]  Yes [ ]  No

If “No”, please specify who did

1. Did you provide periodical assessments/evaluations to the candidate during their training?

[ ]  Yes [ ]  No

1. Was the candidate given written progress reports?

[ ]  Yes [ ]  No

If “Yes”, please specify how often (eg. 3 monthly, twice yearly, yearly)

1. Have you checked and countersigned (ie validated) the candidate’s surgical log-book?

[ ]  Yes [ ]  No

If “No”, please specify who has?

1. Please indicate those aspects of the ICO Fellowship curriculum the Candidate HAS NOT COVERED during their Fellowship with you ([see p7-18 in this document](http://www.ebo-online.org/wp-content/uploads/ICOsubspecialty-curriculum-oculoplastic-and-facial-surgery.pdf))
2. Please indicate any issues relating to the ethical and professional conduct of the candidate while training with you. If NONE, please state “None”

**Details of Institution**

1. Is your department of Ophthalmology part of an academic institution?

[ ]  Yes [ ]  No

If “Yes”, please specify which

1. Is the Residency programme in Ophthalmology at your institution a minimum of 4 years?

[ ]  Yes [ ]  No

If “No”, please specify the number of months \_\_\_\_\_\_\_\_\_\_\_\_

1. Did the candidate complete their residency in your institution?

[ ]  Yes [ ]  No

If “No”, please specify where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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

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

[ ]  Yes [ ]  No

If “NO”, please indicate what is lacking