

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): _____

Work address:

Institution: _____

Street: _____

City: _____

Postcode: _____

Country: _____

Languages spoken:

(i) _____

(ii) _____

(iii) _____

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 _____

6) 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: _____

7) 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**.

a. Institution name and address

Name: _____

Address: _____

b. Dates

Start date: _____ End date: _____

c. 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:

(i) actively supervise your training?

Yes No

- (ii) evaluate you periodically?
 Yes No
- (iii) provide progress reports?
 Yes No
- (iv) 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.

8) Present appointment

9) Date of appointment

10) Clinical responsibilities

11) Training responsibilities (medical students/residents/Fellows)

12) 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

13) Published articles

14) Scientific research grants

15) Awards

16) Membership of scientific or professional bodies

17) 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**.

a. Institution name and address

Name: _____

Address: _____

b. Dates

Start date: _____ End date: _____

c. 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:

(i) actively supervise your training?

Yes No

(ii) evaluate you periodically?

Yes No

(iii) provide progress reports?

Yes No

(iv) validate your surgical log-book?

Yes No

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**.

a. Institution name and address

Name: _____

Address: _____

b. Dates

Start date: _____ End date: _____

c. 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:

(i) actively supervise your training?

Yes No

(ii) evaluate you periodically?

Yes No

(iii) provide progress reports?

Yes No

(iv) validate your surgical log-book?

Yes No