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

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