

Email: claudine@asiacorneasociety.org

## APPLICATION FOR ASIA CORNEA SOCIETY – SANTEN ASIA EDUCATIONAL GRANT FOR CORNEAL OBSERVERSHIP

THIS APPLICATION WILL BE CONSIDERED ONLY WHEN YOUR OBSERVERSHIP IS ACCEPTED BY THE TRAINING INSTITUTION.

### INSTRUCTIONS

Please read the instructions carefully before completing the form.

i)	I wish to embark on this training attachment to achieve the learning objectives (Please be as specific as possible):  a							
	b							
	с							
ii)	Please discloundertaken	ose your clinician experience/research experience for example, surgeries performed, research projects etc. (Compulsory) eed to have completed at least one (1) year of corneal fellowship.						
iii)	Please enclo	se copies of your medical and corneal training, transcripts of academic results and testimonials						
1. P	PERSONAL PAR	TICULARS						
Nar	me:	Passport No:						
	W★CO-7/15C31D0319W	ne family name or surname)						
Hor	me Address:							
	- :-	Country:						
Pos	tal Address: _							
		Country:						
Tel	(Office):	Tel (Residence):						
Мо	bile Phone:	Fax:						
E-m	nail:	Gender:						
Dat	e of Birth:	Age: Nationality:						



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## 2. PRE-MEDICAL EDUCATION

From	То	Name of School/College	Country	Qualification Attained

## 3. MEDICAL SCHOOL BASIC DEGREE

From	То	Name of Medical School	Country	Language of	Qualifications Attained
				Instruction	

## 4. OTHER DEGREES /HONOURS /FELLOWSHIPS /POSTGRADUATE COURSES

From	То	Name of Institution	Country	Language of Instruction	Qualifications Attained or Specialty

### 5. CORNEA SURGERIES PERFORMED

Title of Surgeries Performed	Number of Surgeries Performed



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## 6. HOUSEMANSHIP

From	То	Name of Institution	Country	Specialty

## 7. RESIDENCIES

From	То	Name of Institution	Country	Specialty

## 8. PAST AND PRESENT APPOINTMENTS AND PROFESSIONAL EXPERIENCE

(INSTITUTIONAL & PRIVATE)

То	Name of Hospital	Country	Medical Staff Position
	,		
	То	To Name of Hospital	To Name of Hospital Country

## 9. PAST AND PRESENT TEACHING POSITIONS (IF APPLICABLE)

То	Name of Medical School or Institution	Country	Faculty Position and Department
	То	To Name of Medical School or Institution	To Name of Medical School or Institution Country



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## 10. PERCENTAGE OF PRACTICE: GENERAL OPHTHALMOLOGY/SUB-SPECIALTIES

Name of Sub-specialty Field	Percentage of Work in Special Field
	%
	%
	%

#### 11. PROFESSIONAL MEMBERSHIPS

Date	Society	Title/Memberships

## 12. PUBLICATIONS (ATTACH SEPARATE SHEET IF NECESSARY)

Date	Journal	Title/Co-Authors

# 13. LIST ATTENDANCE AT REGIONAL/INTERNATIONAL SCIENTIFIC MEETINGS AND INDICATE IF PRESENTED PAPERS OR CO-ORDINATED/CHAIRED SESSIONS

Year	Name of Meeting	If Presented Papers, Posters or co-ordinated sessions, please give details



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## 14. 5 REFEREES\* (At least 2 Referees.)

Full Name	Address, Fax No. and Email Address	Designation,
		Institution & Country of Work
* Referees should either be	department heads or direct supervisors who ar	re familiar with your work.
15. DECLARATION		
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I declare that the infer	mation given in the application are two to the	a bast of my knowledge and that I have not
wilfully suppressed any	mation given in the application are true to the material fact.	e dest of my knowledge and that I have not

5. DECLARATION	
I declare that the information given in the wilfully suppressed any material fact.	he application are true to the best of my knowledge and that I have no
Date	Signature of Applicant