APPLICATION FOR EUROPEAN BOARD OF SURGERY QUALIFICATION IN BREAST SURGERY

FAMILY NAME **FIRST NAME(S)**

…….. ……..

NATIONALITY **DATE AND PLACE OF BIRTH**

…… ……..

ADDRESS FOR CORRESPONDENCE **HOME ADRESS (if different)**

…… ……

…… ……

TELEPHONE **FAX** **E-MAIL**

…… …….. ……..

PRESENT APPOINTMENT (title, department and hospital address)

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……..

UNDERGRADUATE AND POSTGRADUATE MEDICAL EDUCATION

Medical Degree (please provide certified copies of the relevant certificates translated in English if not in English originally)

Institution	Dates (from-to)	Degree
……	……	……
……	……	……
……	……	……
……	……	……
……	……	……
……	……	……

Surgical specialty training (please provide certified copies of the relative certificates translated in English if not in English originally)

Institution	Dates (from-to)	Degree
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……	……	……
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BREAST SURGERY TRAINING (please provide certified copies of the relative certificates translated in English if not in English originally)

Institution	Dates (from-to)	Degree
……..	……	……
……..	……..	…….
…….	……	……
……..	……	……
……..	……..	…….
…….	……	……

TOTAL DURATION OF TRAINING IN BREAST SURGERY

Years …… Months ……..

DECLARATION BY THE APPLICANT

I hereby apply for Eligibility of the European Board of Surgery Qualification (EBSQ) in Breast Surgery which I understand may be awarded upon the recommendation of the Breast Surgery Division based upon assessment of my training experience. I declare that all information provided on this form in support of my application is correct.

Signature ……

Print name ……..

Date ……..

NAME AND HOSPITAL ADDRESS OF TWO PRINCIPAL TRAINERS IN BREAST SURGERY

1 ……..

2 ……