# Application Form 2017
## Advanced Examination for Ophthalmologists

Please complete ALL SECTIONS (BOTH SIDES) of this form using CAPITAL LETTERS or a typewriter.

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1. | **First name**: ____________________________  
**Surname**: ____________________________  
PRINT your name exactly as you wish it to appear on a certificate (for example ALEXANDRA CESAR BELL)  
Your name on all the documents, including the certificate, will be printed exactly as you write it on this application form.  
Please be sure that it is correct as no further changes will be allowed. |
| 2. | **Address**: __________________________________________  
**City**: ____________________________  
**Postal Code**: ____________________________  
**Country**: ____________________________ |
| 3. | **Gender**:  
- Male [ ]  
- Female [ ]  
**Nationality**: ____________________________ |
| 4. | **Telephone number** (including country code)  
**Email address**  
**Date of birth**  
**Date of local face-to-face examination**  
**Name and address of co-ordinator (if known)**  
**Date you started training in Ophthalmology**  
Please turn over for questions 12-17 |
| 5. | **You need to have a certificate for the ICO Clinical Sciences Examination for Ophthalmologists.**  
Please attach a copy of the certificate. Failure to attach a copy will result in a delay of your certificate and analysis being dispatched.  
I have passed (name and date of examination)  
**Examination number**: ____________________________  
**For Office Use Only**  
**International Examinations**  
**Please attach a good quality passport-size photograph. The photograph will be scanned.** DO NOT STAPLE |
| 6. | |
12. Degree(s)/Qualifications (with dates)

___________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________

13. Medical Registration/Licence to practice, date and details

___________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________

14. Present place of work

___________________________________________________________________________________________________________________________________

15. I agree that my name can appear on the ICO website and that my photograph may be reproduced by the ICO in connection with the Examination(s)
   Please tick (✓) the box and sign point 16

16. Signature of candidate

___________________________________________________________________________________________________________________________________

17. Date of application

___________________________________________________________________________________________________________________________________

Please return this completed form before 31 July 2017 to:

International Council of Ophthalmology, Unit 2, Forest Industrial Park, Forest Road, Ilford, London IG6 3HL
Email: nquilter@icoph.org

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