



ESCRS TRAINEE VERIFICATION FORM

Please complete this page to upload it as part of the ESCRS online registration process for ophthalmologists in training/residency programmes.

Registrant

Date of Birth(dd/mm/yy): _____

First name: _____ Last name: _____

Place of Employment/Educational Institute

Name: _____

Department: _____

Street: _____

Postal Code: _____

City: _____

Country: _____

Office/Institute Stamp

Confirmation:

I, (Title)_____ (First Name)_____ (Last Name)_____, as the above-mentioned applicant's (position)_____, confirm that they are currently an ophthalmologist in training/a residency programme.

Supervisor's signature: _____

Applicant's signature: _____ Date: _____

Thank you for completing your ESCRS trainee verification form. Please have it ready to be uploaded for the online registration process. If you have any further queries, please contact registration@escrs.org.

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