

## APPLICATION FOR FELLOWSHIP

**Units:** (Mention the preference numbers)

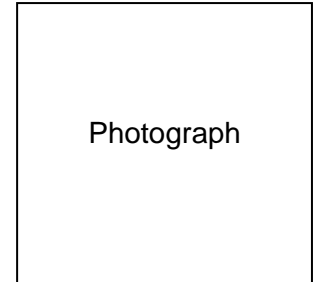
- Bengaluru  Coimbatore  Krishnankovil  Guntur  
 Ludhiana  Kanpur  Shimoga  Anand

**Subspecialty** (put a tick (√) mark for one sub-specialty only)

- Cataract & IOL  Cornea  Medical Retina  Oculoplasty  Pediatrics  Glaucoma

**Source of Application:** (select with (√) mark)

- IJO  Sankara Website  Friend Reference  Direct  Any Other Source \_\_\_\_\_



### **INSTRUCTIONS**

Please read the instructions carefully before filling the form.

- i) All sections are to be filled. If not applicable, indicate "NA".
- ii) Enclose copies of your basic and post-graduate educational certificates, current valid medical registration license and a passport-sized photograph.
- iii) The duly completed application form to be submitted as a softcopy via email to [careers.seci@sankaraeye.com](mailto:careers.seci@sankaraeye.com) and [director.sav@sankaraeye.com](mailto:director.sav@sankaraeye.com)

Send hard copy of the same along with accompanying documents, photograph & DD ₹ 500/- in the name

“S K K M TRUST- Sankara Academy of Vision” payable at Coimbatore to the address given below:

“The Director, Sankara Academy of Vision, Varthur Main Rd, Kundalahalli Gate, Bengaluru – 560037”

### **1. PERSONAL COLUMN**

Name in Full: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

\_\_\_\_\_ Country: \_\_\_\_\_

Present Address: \_\_\_\_\_

\_\_\_\_\_ Country: \_\_\_\_\_

Tel (Office) : \_\_\_\_\_ Mobile No.: \_\_\_\_\_

E-mail : \_\_\_\_\_ Nationality: \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Age: \_\_\_\_\_ Passport No (Foreign Nationals): \_\_\_\_\_

**2. BASIC DEGREE (MEDICAL)**

Name of Institution	From	To	Board / University	Qualification

**3. POSTGRADUATION**

Name of institution	From	To	Board / University	Qualification

**4. OTHER DEGREES/HONOURS/FELLOWSHIPS (If any)**

Name of institution	From	To	Board / University / other Sponsoring body	Qualification

**5. PRESENT LEVEL OF COMPETANCY**

Surgical procedures	No of surgeries performed under supervision	No of surgeries performed independently	Competency level (scale of 1 – 5)
ECCE			
SICS			
PHACO			
Trabeculectomy			
Retina lasers			
DCR			
others			

**6. PRESENTATIONS / PUBLICATIONS (ATTACH SEPARATE SHEET IF NECESSARY)**

Date	Journal	Title/Co-Authors

**7. REFEREES\***

Full Name	Address, Fax No. and Email Address	Designation, Institution & Country of Work

*\* Referees should either be department heads or direct supervisors who are familiar with your work.*

**8. GIVE BELOW ANY OTHER INFORMATION YOU FEEL RELEVANT TO YOUR APPLICATION**

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**DECLARATION**

I declare that the information given in the application is true to the best of my knowledge.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant