SANKARA ACADEMY OF VISION
(Unit of Sankara Eye Foundation, India)
Varthur Main Rd, Kundalahalli Gate, Bengaluru – 560037
Phone: +91 80 28542727/28 Web: www.sankaraeye.com

APPLICATION FOR FELLOWSHIP

Photograph

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 and 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**"

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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