



**Fellowship Certificate
of the European Board of Nuclear Medicine**

APPLICATION FORM 2010

Please fill in this form (type or write in block letters) and return it **before February 1, 2010** to:
UEMS/EBNM - EANM Executive Secretariat, Hollandstrasse 14/Mezzanine, A-1020 Vienna, Austria
Tel: +43-(0)1-212 80 30, Fax: +43-(0)1-212 80 30-9, E-mail: office@uems.eanm.org, URL: <http://uems.eanm.org>

<u>CANDIDATE</u>	
<input type="radio"/> Prof. <input type="radio"/> Dr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Mr. <input type="radio"/> Other title: _____	
First name :	_____ Middle name: _____
Family name:	_____
Department:	_____
Institute:	_____
Street:	_____
Post Code:	_____ City: _____
Country:	_____ Phone: _____
Fax:	_____ Email: _____

Country and date of the National Board Certificate: _____

LANGUAGE

- I have difficulties with oral expression in English
and I request the presence of an **additional examiner familiar with my language**, which is:

ENCLOSURES

- curriculum vitae [*with a list of training institutions including names of heads of department*]
- copies of certificates [*Specialist in Nuclear Medicine Certificate or Specialist Training Certificate*]
- detailed list of performed nuclear medicine procedures according to the Syllabus 2006/07
- detailed description of continuing medical education after national accreditation [*CME credits*]
- attestation of having successfully passed MCQ [*to be sent if applying for the oral examination only*]

REGISTRATION AND PAYMENT (tick appropriate box)

- Registration fee for both **MCQ and oral examination**: 300 €
- Registration fee for **MCQ exam** only: 200 €
- Registration fee for **oral examination** [year when MCQ was passed: _____] 150 €
- Registration fee for **retakes**: 100 €

INSTRUCTIONS FOR PAYMENT

- Bank transfer** to UEMS/EBNM bank account: (all charges for the ordering customer)
Die ERSTE Bank, Taborstraße 26, A-1020 Vienna, Austria,
Account no: 281 200 399 01, **Sorting Code:** 20111, **IBAN:** AT33 20111 281 200 399 01, **BIC:** GI BA AT WW
stating your name and payment purpose. Please make any transfer free of charge for the beneficiary.
- Credit Card:** American Express Visa Master Card
CC number: _____
Exp. Date: ____ / ____
Name of Cardholder: Signature:

Cancellation: Registration fees, less a 30 € processing fee, will be refunded if a written request is received by March 31, 2010

Date: _____ Signature: _____