

## APPLICATION FORM FOR IFEPAG EXAM

|   |  |
|---|--|
| Name of physician:  |  |
| Phone Number:(country area code- number)  |  |
| E-mail:   |  |
| Passport Number for Written exam On Line:   |  |
| Address:  |  |
| Date of Birth:                      day.....    .month.....    year.....  | Age:                      (years)  |
| Sex: .....  |  |
| Apply for IFEPAG part I: Yes / No (please delete as appropriate)  |  |
| Apply for IFEPAG part II: Yes / No (please delete as appropriate. One must pass IFEPAG I before sitting for IFEPAG II examination; but one can sit both examinations at one time. )   |  |
| <b>BASIC REQUISITES TO APPLY TO THE EXAM (Items 1, 2 and 3)</b>   |  |
| <b>1. Date as physician</b><br>...../...../.....(day/month/year)<br><br>UNIVERSITY:   | Attach Certificate<br>Or send the certificate by email and titled as 'Certificate of graduation' |
| <b>2. Title or certificate of specialty</b><br><div style="text-align: right; margin-right: 50px;">                     Obstet/Gynecology.....II<br/>                     Pediatric .....I<br/>                     Pediatric Surgery .....II<br/>                     Endocrinology .....I                 </div> Initial date: ...../...../.....(day/month/year)<br>Final date ...../...../..... (day/month/year)<br><br>INSTITUTE: ..... | Attach Certificate<br>Or send the certificate by email and titled as 'Certificate of Specialty'  |

|  |                     |                   |                                   |   |
|--|---------------------|-------------------|-----------------------------------|---|
| <b>3. Clinical experience, at least two years in PEDIATRIC AND ADOLESCENT GYNECOLOGY.</b> In case not to have a formal accreditation of this Subspecialty. Please describe places. |                     |                   |                                   |   |
| <b>Institute</b><br><br><b>(IFEPAG I or II training)**</b>   | <b>Initial Date</b> | <b>Final Date</b> | <b>Name of Tutor or Professor</b> | Attach Certificate<br><br>Or send the certificate by email and titled as 'PAG training' |
|  |                     |                   |                                   |   |
|  |                     |                   |                                   |   |
|  |                     |                   |                                   |   |
|  |                     |                   |                                   |   |

\* \* Mark IFEPAG I or IFEPAG II (IFEPAG II includes IFEPAG I)

(Added extra pages if it is necessary)

**4. POSTGRADUATE QUALIFICATION**

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| <p><b>4. Academic Grades (Please do not include title of medical doctor or specialist)</b></p> <p><b>4.1. Diploma in:</b></p> <p style="padding-left: 40px;"><b>University, year:</b></p> <p><b>4.2. Magister or master degree in:</b></p> <p style="padding-left: 40px;"><b>University, year:</b></p> <p><b>4.3. PHD M Dr. PH. In:</b></p> <p style="padding-left: 40px;"><b>University, year:</b></p> | <p>Attach Certificate</p> <p>Or send the certificate by email and titled as 'PAG training'</p> |
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**5. SUBSPECIALTY**

|   |                               |
|---|-------------------------------|
| <p><b>5. Subspecialty in :</b></p> <p>Pediatrics and adolescent gynecology <input type="checkbox"/></p> <p>Pediatric and Adolescente Endocrinology <input type="checkbox"/></p> <p>Pediatric Surgery <input type="checkbox"/></p> <p>Adolescent Medicine <input type="checkbox"/></p> <p>Other (specify)..... <input type="checkbox"/></p> <p>Initial Date : .....(day/month/year)</p> <p>Final Date ..... (day/month/year)</p> <p>N° of hour per week:</p> <p>Institution or University:</p> | <p>Attach<br/>Certificate</p> |
| <p>Initial Date : .....(day/month/year)</p> <p>Final Date ..... (day/month/year)</p> <p>N° of hour per week:</p> <p>Institution or University:</p>  |                               |
| <p>Initial Date : .....(day/month/year)</p> <p>Final Date ..... (day/month/year)</p> <p>N° of hour per week:</p> <p>Institution or University:</p>  |                               |

(Added extra pages if it is necessary)

**6. CONTINUOUS EDUCATION**

Training related to Pediatrics and Adolescent Gynaecology in *recent 3 years*  
-Please list out the Congress / Seminar / Continuous Education meetings / Training program

Name of training: .....

Date (or period): .....

Training duration (hours):.....

Name of training: .....

Date (or period): .....

Training duration (hours):.....

Name of training: .....

Date (or period): .....

Training duration (hours):.....

Name of training: .....

Date (or period): .....

Training duration (hours):.....

Name of training: .....

Date (or period): .....

Training duration (hours):.....

Name of training: .....

Date (or period): .....

Training duration (hours):.....

(Added more pages if it is necessary)

**7. RESEARCH ACTIVITIES**

**7. Publication** IN PEDIATRIC AND ADOLESCENT GYNECOLOGY, on journals of scientific societies with editorial committee (name of the work, author/coauthor, journal, vol. N°, pages) *in recent 3 years*

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(Added more pages if it is necessary)

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SIGN OF THE CANDIDATE

\_\_\_\_\_  
DATE

\* Candidate must be able to submit evidence to support the above information upon request by the examination panel.