
EAA APPLICATION FORM FOR EXAMINATION IN CLINICAL ANDROLOGY

Full name: **Date of birth (dd/mm/yy)**...../...../.....

Name and address of the institution
.....
.....

Phone No:..... **Fax No**..... **E-mail**.....

Medical speciality (if any)

ANDROLOGICAL EDUCATION

Full time appointment at

EAA centre:

Name.....**No months**.....

Name.....**No months**.....

Name.....**No months**.....

Other andrological centres:

Name.....**No months**.....

Name..... **No months**.....

Laboratory work;

Semen laboratory : **No** **Yes** if 'yes' **No months**.....

Other laboratory work: **No** **Yes** if 'yes'

Type..... **No months**.....

Type..... **No months**.....

Clinical experience

The candidate has been primarily responsible for diagnosis/treatment of following numbers of patients*

Male infertility **Hypogonadotropic Hypogonadism**

Erectile dysfunction **Hypergonadotropic Hypogonadism**

Klinefelter's syndrome **Delayed male puberty**

* Some patients (e.g. Klinefelter) may fall into more than 1 category. In such case include in all relevant categories.

I certify the correctness of above information

Director of EAA Centre..... **Candidate**.....

Date.....
