



INSTITUTE FOR
COCHLEAR
IMPLANT
TRAINING

Advanced Surgeon Training Course Application

Today's Date _____

Formal Name, Credentials and Title: (as you would like to have it appear in our publications)

Name and credentials _____

Title _____

Department _____

Institution _____

Contact Info:

Email _____

Cell Phone _____ Work Phone _____

Mailing Address _____

Background/Experience:

Fellowship Program Yes/No Where _____

Board Eligible/Certified _____

Years of Otology Surgery _____

Number of CI surgeries performed: Observed _____ First Assistant _____ Primary Surgeon _____

Please briefly describe your past CI experience and explain your interest in this course: