### LOGO_CARRE_CLAIM_final8 copy.jpg Application for EDIC Part II Examiner

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| --- | --- |
| Name |  |
| First name |  |
| Department |  |
| Hospital name |  |
| Hospital address |  |
| City / Country |  |
| E-mail |  |
| ESICM member | YES/NO (scrub the incorrect answer) |
| EDIC holder | YES/NO (scrub the incorrect answer) |
| Date of EDIC award (DD/MM/YY) |  |
| First time EDIC examiners | YES/NO (scrub the incorrect answer) |
| First time examiners | YES/NO (scrub the incorrect answer) |
| Years of experience as examiner |  |
| Name of National Training Programme |  |
| Position in your national training programme |  |
| Years of experience in post-graduate training |  |

Date of Application: