EBIR

European Board of Interventional Radiology

Date:

Proof of Radiology and IR training

This is to certify that

☐ Female ☐ Male ☐ Prof. ☐ Dr. (please indicate)

Family Name: First Name:

Training institution:

Street / no:

City: Zip Code: Country:

has completed his/her national Radiology training in the year as well as at least 1 year of IR training (from to) and is currently working as fully qualified staff radiologist in the below stated hospital / institution.

Name and address of current hospital / institution:

Institution:

Street / no:

City: Zip Code: Country:

Phone: Fax:

E-mail:

Official stamp of current hospital / institution:

Name and function of undersigned in block letters

Signature of authorised representative
(Director of the current hospital or Programme Director of IR or Radiology Department)