

GAASS Application Package

Fellowship Director: **IKE K. AHMED MD, FRCS(C)**
Glaucoma, Cataract & Anterior Segment Surgery Ophthalmology



Ophthalmology & Vision Sciences
UNIVERSITY OF TORONTO

Dear Applicant,

Thank you very much for your interest in our Fellowship programs. To apply, please ensure that the following documents have been completed:

- Completed GAASS Fellowship Application (attached)
- Cover letter/personal statement expressing your objectives, special skills and expertise
- Up-to-date curriculum vitae
- Medical School transcript
- Current photograph
- Surgical video (optional) featuring your surgical technique (i.e., cataract/IOL and/or glaucoma surgery). Please provide links to view videos online (YouTube, Vimeo, etc.). If necessary, a DVD may be provided.
- Three letters of reference (see application for details). These letters cannot be provided by the applicant - please have the referrers send the letters directly (through email or courier to the addresses provided below).

Please provide all application materials as a complete package - do not send elements separately. Completed applications and supplemental materials can be emailed (preferred) as PDFs to Daisy@prismeye.ca or couriered/mailed to:

Prism Eye Institute
2201 Bristol Cir, Suite 100
Oakville, ON L6H 0J8
Attn: Daisy Huerto

Applications are due before August 31 of the year prior to beginning the fellowship but are preferred earlier.

Once your completed application has been received, you will receive a confirmation from our office. To help manage the high volume of inquiries, we ask that once you have submitted your application that you wait to be contacted by our offices.

Before submitting, please ensure you are familiar with the fellowship description available here - <http://ophthalmology.utoronto.ca/glaucoma-and-advanced-anterior-segment-surgery-gaass>

We truly appreciate your interest in our fellowship programs. We will contact you should we request an interview or further information. We do receive a large number of excellent applications each year, making the selection process very competitive and difficult. I wish you the very best in your academic endeavors.

Sincerely,

Ike K. Ahmed, MD, FRCS(C)

Assistant Professor, University of Toronto

Fellowship Director, Glaucoma and Anterior Segment Surgery (GAASS) Fellowship, University of Toronto

Research Fellowship Director, University of Toronto, Department of Ophthalmology and Vision Sciences

Professor, University of Utah



2201 Bristol Cir, Suite 100, Oakville, ON L6H 0J8

www.prismeyeinstitute.com

phone 905.456.3937

fax 905.820.0111

GAASS FELLOWSHIP - APPLICATION FORM



Ophthalmology & Vision Sciences
UNIVERSITY OF TORONTO

Please complete and include this application as a part of your GAASS Fellowship application package - see page 1 for details.

Name: _____

Date: _____

APPLICATION TYPE (please select 1)

CLINICAL FELLOWSHIP - 1 YEAR

Desired Start Date:
(Whenever possible, Clinical Fellowships should begin in July or August)

CLINICAL/RESEARCH COMBINED FELLOWSHIP - 2 YEARS

Desired Start Date:
(Whenever possible, Clinical/Research Fellowships should begin in July or August)

CLINICAL FELLOWSHIP - 2 YEARS

Desired Start Date:
(Whenever possible, Clinical Fellowships should begin in July or August)

RESEARCH FELLOWSHIP - 1 YEAR

Desired Start Date:
(Whenever possible, Clinical Fellowships should begin in July or January)

CONTACT INFO

Name:

Current Address:

Date of Birth:

Place of Birth:

Citizenship(s):

Email:

Home Phone:

Work Phone:

Mobile Phone:

Emergency Contact:

Emergency Contact Phone:

CURRENT POSITION

Ophthalmology Resident Other:

Medical License(s) (Jurisdiction/Number):

Other Certification(s):

EDUCATION/TRAINING

Time period from College graduation to present should also be included. Please explain any significant gaps.

| Institution | City/State/Country | From (MM/YY) | To (MM/YY) | Degree or Major |
|-------------|--------------------|-----------------|---------------|-----------------|
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POST-TRAINING WORK (if applicable)

| Institution | City/State/Country | From (MM/YY) | To (MM/YY) | Duties |
|-------------|--------------------|-----------------|---------------|--------|
| | | | | |
| | | | | |
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ACCOMPLISHMENTS

Please list honors, awards, and other academic accomplishments:

Please list publications:

SURGICAL EXPERIENCE (Clinical Fellow Applicants only)

The GAASS clinical fellowship is a surgically intensive program. Please summarize your surgical experience thus far as well as expected number at start of fellowship (i.e., Number and type of surgical cases completed as primary surgeon).

SURGICAL COMPETENCY (Clinical Fellow Applicants only)

Please assess your surgical competency with the following:

| | NO EXPERIENCE | SOMEWHAT COMFORTABLE | VERY COMFORTABLE |
|---|--------------------------|--------------------------|--------------------------|
| 1. Routine phacoemulsification: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Complex phacoemulsification: (small pupil, dense cataract. +/- loose zonules) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Routine glaucoma filtering surgery: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Complex anterior segment surgery (IOL repositioning, iris suturing. etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please check YES or NO for the following. If Yes for any question, please provide explanation below.

- | | | |
|--|------------------------------|-----------------------------|
| Have you ever had an application for medical licensure denied? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever had a medical license revoked? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever been convicted of a felony? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever been found guilty of academic misconduct? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have any physical disability or chronic illness? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you feel you may be unable to perform any duties or the fellowship? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Provide details for any Yes answers:

REFERENCES

Letters or reference should be from the chairman and/or director or your ophthalmology residency program (for Clinical Fellowship Applicants), and two other Individuals who are able to assess your abilities. PLEASE NOTE: These letters should not be seen by the applicant. Letters should be sent directly from the referrer (see page 1 for address/email).

Please list the 3 referrers providing your letters of recommendation (Name, Position, Institution, City):

- 1.
- 2.
- 3.

FUNDING

Funding is provided to all Clinical Fellows. If applicable, list any additional sources of funding you have secured or applied for:

PROFESSIONAL GOALS

Please briefly state your professional goals, and how you feel this fellowship will aid in achieving these: