## Host center application form

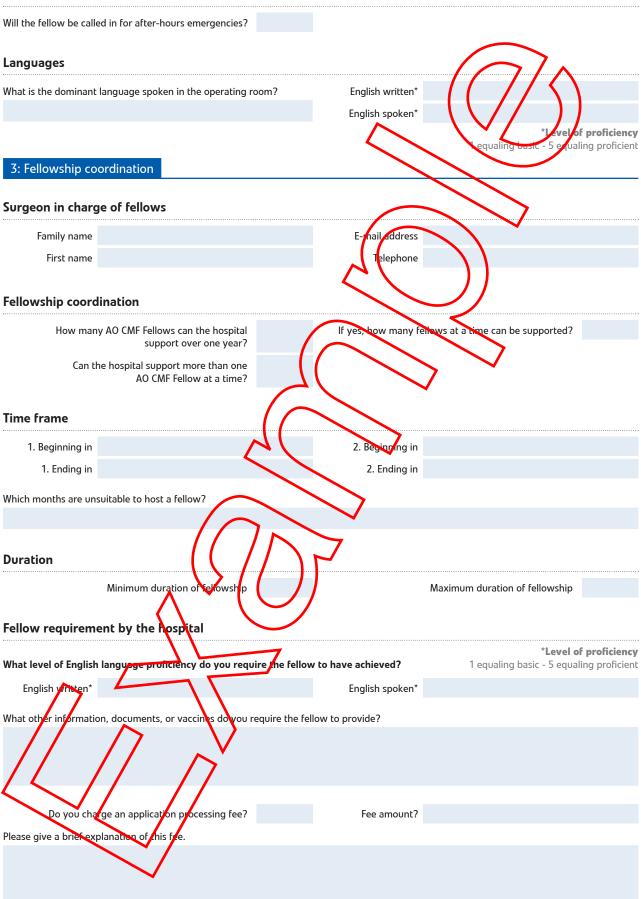
1: Contact information Host center contact information Name of hospital Street address lephone Website addres Postcode/zip code City Country State/region Host center Practice settings Department Department name Head of craniomaxillofacial (CMF) department/center Family name E-mail address First name Telephone Second contact Family name E-mail address First name Telephone Third contact Family name E-mail address Telephone First name AO CMF faculty members Number of AO CMF facult members AO CMF acul members



### 2: Department information

# **D**epartment information Number of beds in department How many patients visit the ovepatient clinic per week? Number of cases per year Total surgical cases per year Subspecialties available to the fellow Number of cases per year. Trauma nplant/preprosthetic Oncological and microvascular flap reconstruction Aesthetic surgery Orthognatic surgery Temp romandibular joint (TMJ) 3D virtual planning and patient-specific implants Cleft and pediatric syndromic surgery Orbit and adult craniofacial Additional subspecialties Other activities Other hospital activities in which an incrested fellow coul parti Scrub in opportunity for the AO Fellows to scrubin? Is the e an , is there any addicional / special license required to scrub in? lf y If no, please explain why this poot possible?

### After-hours duties





## 4: Accommodations

### Accomodation

Does the hospital have on-site accommodation?	
If yes, what is the approximate rent of the room per week?	
Contact family name	Contract E-mail
Contact first name	
If no, what accomodation options are available privately?	
Distance to hospital	()
Remarks	
Additional notes and remarks	> > >
	✓