

**Association of University Professors of Ophthalmology
Fellowship Compliance Committee**

Faculty Signature Page

As Fellowship Program Director, I certify to the best of my ability, that the foregoing information is an accurate reflection of this proposed program

(Signature): _____

Print Name: _____

Print Program Name: _____

Date: _____

Teaching Faculty:

(Signature): _____ (Printed Name): _____

(Signature): _____ (Printed Name): _____

(Signature): _____ (Printed Name): _____

(Signature): _____ (Printed Name): _____

(Signature): _____ (Printed Name): _____

(Signature): _____ (Printed Name): _____

This Fellowship Program has the support of the affiliated Department of Ophthalmology (when applicable) listed on page 1.

(Signature, Department Chair): _____

Print name: _____

Please retain a copy of this form for your records and return the original to:

AUPO FCC
655 Beach St.
San Francisco, CA 94109
(415) 561-8548