ACCREDITATION APPLICATION FORM FOR THE EUROPEAN SOCIETY FOR SEXUAL MEDICINE FEMALE ULTRASOUND SCHOOL (EFUS) TRAINING CENTER

Center Information:

- **Name of the Center:**
- **Contact Person**
  - Name:
  - Position:
  - Email:
  - Phone Number:

Clinical Activities:

- **Number of Female Patients Seen per Month for Sexual Health Issues:**
- **Types of Services Offered:**
  - (Please specify)

Ultrasound Equipment:

- **List of Ultrasound Equipment Available:**
  - (e.g., Model, Type, Year of Acquisition)

Staff Qualifications:

- **Names and Qualifications of Staff Members:**
  - (Please provide the names and qualifications of all team members involved in the service)
- **Is there in the Center faculty at least one member that is part of the EFUS faculty or has received the EFUS training (theoretical and practical)**
  - Yes / No
  - If Yes, please provide the name and qualifications:

Additional Information:

- (Any other relevant information or comments)