



Changing Lives One Smile at a Time

Dear Medical Volunteer Applicant:

Thank you for your interest in becoming a medical volunteer! As you know, we rely on volunteers to give their time and expertise to help children at home and around the world.

Enclosed you will find a volunteer application. To help expedite the application process, please submit the completed application along with:

- Current Curriculum Vitae/Resume
- Copy of diploma(s)
- Current licensure
- Current board certification
- 3 References – contact information only

Please do not send incomplete application packages. Upon receipt of your complete application packet, it will be forwarded to the Medical Officer for review. The officer may telephone you to clarify information and will determine the status of your application. This process can take up to 8 weeks.

We will inform you of the results of your application. Upon approval by the Medical Officer, an applicant will be entered into the medical volunteer database, indicating eligibility to participate on a relief mission.

We are all blessed with the ability, because of what we know, to give something to the world that will be highly appreciated. We admire your desire to help others and look forward to building a better world together.

We look forward to hearing from you soon. If you have any questions, please feel free to contact the Medical Volunteers Department at 1-888-OPSMILE (888-677-6453) or via e-mail at credentialing@operationsmile.org.

Best regards,

Medical Volunteers Department
Nikki Holloman – nholloman@operationsmile.org
Kelly Roenker – kroenker@operationsmile.org



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DISASTER RELIEF MEDICAL VOLUNTEER APPLICATION

Name: _____
 (Last) (First) (Middle)

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Place of Work: _____ Position: _____

Work Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Preferred Mailing Address (check one): _____ Home Address _____ Work Address

PLEASE INDICATE YOUR MEDICAL SPECIALTY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Technician: Adv X-Ray |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Technician: Biomedical Equip |
| <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Optician | <input type="checkbox"/> Technician: Cast Room |
| <input type="checkbox"/> ER Specialist | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Technician: Dental |
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Otorhinolaryngology | <input type="checkbox"/> Technician: Dental Surgery |
| <input type="checkbox"/> Infectious Disease Physician | <input type="checkbox"/> Pathologist | <input type="checkbox"/> Technician: Dialysis |
| <input type="checkbox"/> Internist - Pulmonologist | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Technician: ENT |
| <input type="checkbox"/> Internist: Cardio | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Technician: Pharmacy |
| <input type="checkbox"/> Internist: Critical Care | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Technician: Physical Therapy |
| <input type="checkbox"/> Nephrologists | <input type="checkbox"/> Physician Asst. | <input type="checkbox"/> Technician: Prev Med |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physician Asst. - Ortho | <input type="checkbox"/> Technician: Res & Ther |
| <input type="checkbox"/> Nurse Anesthesiologist | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Technician: Surgical |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nurse: Critical Care | <input type="checkbox"/> Psychologist | |
| <input type="checkbox"/> Nurse: ER/Trauma | <input type="checkbox"/> Surgeon: General | |
| <input type="checkbox"/> Nurse: Operating Room | <input type="checkbox"/> Surgeon: Oral | |
| <input type="checkbox"/> Nurse: Peds/Family Practice | <input type="checkbox"/> Surgeon: Orthopedic | |
| <input type="checkbox"/> Nurse: Perioperative | <input type="checkbox"/> Surgeon: Orthopedic (Peds) | |
| <input type="checkbox"/> Nurse: Psych | | |



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CURRENT EXPERIENCE: Please indicate which types of patients/programs you have had experience with in the last 3-5 years, and describe your current work.

____ Pediatrics (0-6 years old)

____ Burns

____ Youth (7-14 years old)

____ Orthopedics

____ Adult (over 14 years old)

____ Craniofacial

____ Other: _____

Please briefly describe the nature of your current work below:

Instructor Certification: If you are a certified instructor for CPR or PALS, please check the appropriate box(es) and include a copy of your Instructor Certificate with your application.

BLS Instructor

PALS Instructor

Have you ever participated in any overseas medical/healthcare work?

YES

NO

If YES, explain: _____

Have your medical privileges ever been suspended? YES

NO

If YES, explain: _____

Do you have any outstanding malpractice actions? YES

NO

If YES, explain: _____

Languages spoken and sign language (please indicate level of fluency): _____

6435 Tidewater Drive, Norfolk, VA 23509 (757) 321-7772 Fax

www.operationsmile.org

Please Indicate Your Availability:

- I am available from (date) _____ to (date) _____
- I am available on short notice: ____ 1-2 weeks notice; ____ 3–4 weeks notice
- I am NOT available on short notice

Short notice availability does not affect the application process but allows Operation Smile to adjust to the changing circumstances of our mission countries and volunteers.

PASSPORT INFORMATION

Passport#: _____ Passport Type: _____

Date of Birth: _____ Place of Birth: _____

Nationality: _____

Issuing Authority name and city: _____

Date Issued: _____ Expiration: _____



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REFERENCES

Please provide information for three individuals from within your specialty who can attest to your clinical ability, professionalism, and ability to work as a part of a team in high-stress situations. Our credentialing department may contact these references during the application review.

Reference #1

Name: _____

Position: _____

Company/Hospital: _____

Telephone #: _____

Email: _____

For how long did you work closely with this reference? _____ years _____ months

In what capacity did you work with this reference? _____

Is this reference an Operation Smile volunteer? (circle) YES NO

Reference #2

Name: _____

Position: _____

Company/Hospital: _____

Telephone #: _____

Email: _____

For how long did you work closely with this reference? _____ years _____ months

In what capacity did you work with this reference? _____

Is this reference an Operation Smile volunteer? (circle) YES NO

Reference #3

Name: _____

Position: _____

Company/Hospital: _____

Telephone #: _____

Email: _____

For how long did you work closely with this reference? _____ years _____ months

In what capacity did you work with this reference? _____

Is this reference an Operation Smile volunteer? (circle) YES NO



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APPLICATION PROCESS:

Please send this completed application along with:

- Current Curriculum Vitae/Resume
- Copy of diploma(s)
- Current licensure
- Current board certification
- 3 References – contact information only

It is very important that you send all of the above information together with the completed application. If any of the above information is not in the application packet, the application is considered incomplete. You will be notified if your application is incomplete.

Completed application packets will be sent to a corresponding medical council for review at which time you may be interviewed by telephone or asked to submit additional information. We will inform you of the results of your application.

Please fax all forms to: 757-321-7772

OR

Please mail all forms to:

**Operation Smile
Medical Volunteer Management
6435 Tidewater Drive
Norfolk, VA 23509-1600
USA**

I have read the above and certify that the foregoing is true, correct and complete. I shall promptly inform Operation Smile if there is any change to the facts herein.

Signature: _____

Date: _____