Resident Leadership Program Guidelines

Operation Smile's commitment to all of its patients includes the development of future medical volunteers to continue the delivery of care. Also of great importance is the investment in research on cleft lip/ cleft palate, to better understand the condition and to improve treatment. Under the Resident Leadership Program, medical residents are offered the opportunity to attend a medical program where they will gain invaluable experience working alongside experienced Operation Smile medical professionals.

Resident Profile

- Residents in their final year of study of Anesthesia, Plastic and Reconstructive Surgery and Pediatrics can apply for the Resident Leadership Program.
- Candidates must demonstrate an interest in global medicine and humanitarian aid and a desire to engage in voluntary service.
- A letter of recommendation from a senior faculty member or Operation Smile volunteer must attest to the resident's personal and professional strengths.
- Residency Program Director must approve of resident's participation in Resident Leadership Program.

Expectations of Residents

- Residents will review program preparation documents, attend an Operation Smile medical program, and may be invited to attend an annual Operation Smile conference.
- Residents will agree to full responsibilities of team membership. This includes agreeing to the Code of Conduct for volunteers on medical programs.
- During the medical program, Residents will be assigned specific responsibilities according to their specialty and the nature of the medical program. *(see next section)*
- Participation in Operation Smile medical programs will always take place under the supervision of a mentoring physician.
- Residents will be required to submit a brief paragraph and some pictures about their experience during the Operation Smile medical program.

Tasks/Roles

- During screening, the resident will assess patients alongside other physicians.
- During surgery week, the fellow will assist his/her mentor.
- Specific activities will be assigned by the mentor throughout the medical program.

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

Gender: Male (____) Female (____) Home Phone: (_____)_____

Mobile Phone:(_____)_____ Fax: (_____)_____

(Please include country code and area code for phone #s)

Email:_____

Home Address:_____

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

Employer: _____

Work Address: _____

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

Preferred Mailing Address (check one): ____Home Address ____Work Address

Approval from Residency Program Director

Name: _____ Title: _____

Institution: _____

Email: _____ Phone: (_____) _____

I confirm that the resident in good standing with our program, with a scheduled graduation date of _____. I approve and support the resident in applying for the Resident Leadership Program.
Month / Year

Signature: _____ Date: _____

Residency program director and/or name of Operation Smile volunteer sponsoring this application:

Name: _____

Title: _____

Email:_____ Phone: (_____) _____

DATE RANGE AVAILABILITY: Please indicate your preferences.

1. **From:** _____ (Day / Month / Year)**To:** _____ (Day / Month / Year)
2. **From:** _____ (Day / Month / Year)**To:** _____ (Day / Month / Year)
3. **From:** _____ (Day / Month / Year)**To:** _____ (Day / Month / Year)

DISCIPLINE: Please indicate if subspecialty within your field. Examples (Pediatric Anesthesia, Pediatric Intensive Care)

____ Anesthesia **Subspecialty: _____**

____ Plastic and Reconstructive Surgery **Subspecialty: _____**

____ Pediatrics **Subspecialty: _____**

Expected Completion Date of Residency: _____ (Year and month if possible)

CURRENT EXPERIENCE: Please check areas of experience during your training program. Check all that apply.

____Pediatrics (0-6 years old)
____Youth (7-14 years old)
____Adult (over 14 years old)
____Burns
____Orthopedics
____Craniofacial

Please provide details and dates of any fellowships you are currently in or have completed:

_____

_____

Subspecialty Training:	School / Hospital
Cleft Lip	
Cleft Palate	
Burns	
Flaps	
Microsurgery	
Pediatric Anesthesia	
Pediatric intensive care	
Other	

Board Certified: ❑ YES Specialty:_____ Date:_____ ❑ NO
Day / Month / Year

Board Eligible: ❑ YES Specialty:_____ Date: _____ ❑ NO
Day / Month / Year

Have your medical privileges ever been suspended? ❑ YES ❑ NO

If YES, please explain:_____

_____

Preferred but not required:

BLS Certification: ❑ YES ❑ NO Certification Date: _____
Day / Month / Year

PALS Certification: ❑ YES ❑ NO Certification Date: _____
Day / Month / Year

Operation Smile currently offers BLS and PALS courses in its mission countries. If you are also certified as an instructor please notify us if you are interested in volunteering for AHA (American Heart Association) programs.

❒ BLS Instructor ❑ PALS Instructor

Have you ever participated in any overseas medical/healthcare work? ❑ YES ❑ NO

If YES, explain: _____

First/Native language: _____

Foreign languages and sign language (please indicate level of proficiency):_____

_____

T-Shirt Size: ❑ XS ❑ S ❑ M ❑ L ❑ XL Lab Coat Size: ❑ XS ❑ S ❑ M ❑ L ❑ XL

PASSPORT INFORMATION

Passport #:_____ Passport Type:_____

Date of Birth:_____ Place of Birth:_____
Day / Month / Year

Nationality:_____

Issuing Authority Name and City:_____

Date Issued:_____ Expiration:_____
Day / Month / Year Day / Month / Year

APPLICATION PROCESS:

Please send this completed application along with:

- **Current curriculum vitae/resume**
- **Current copies of licensure**
- **Current copy of board certification** (if applicable)
- **Copies of diplomas and degrees**
- **Current copy of ACLS and/or PALS certification** (if available)
- **Letter of advocacy from your Residency Program Director and/or Operation Smile volunteer sponsoring your application**

Curriculum Vitae should include full contact information including permanent residence in addition to current residence, education history, current certifications, society memberships, publications, employment history, volunteer history, and other information indicating the applicant's humanitarian efforts. Copies of licensure, board certifications, medical degrees and life support certifications do not need to be certified originals specifically for this Operation Smile application, but must arrive fully legible.

Letter of advocacy should include a clear statement that the author is well informed of the activities, performance and commitment of the applicant. It should also make a strong statement on the benefit for the participant and the mission if the applicant is selected.

Please have letters of advocacy addressed to Dr. Jeffrey Marcus, Chair of Resident Leadership Program. If from resident's program director, the letter should be printed on institution's letterhead. Letters from Operation Smile medical mission volunteers should itemize mission participation history with year(s) and site(s). All letters should include contact information from the author.

ALL REQUIRED DOCUMENTS MUST BE SENT WITH COMPLETED APPLICATION
Incomplete packages will result in processing and medical program placement delays.

Applicants will receive email notification of application results.

Completed application packets will be sent to the Dr. Jeffrey Marcus, Chair of the Resident Leadership Program, for review, at which time you may be interviewed by telephone or asked to submit additional information. Operation Smile will inform you of the results of your application. Participants join the program as an Operation Smile Volunteer. All expenses related to the program will be covered by Resident Leadership Program funding unless otherwise indicated.

Participation on a medical program is a privilege and an honor. Volunteers regularly report it is one of the most intense, powerful and life-changing events they have ever experienced. This application is your key to that experience.

There are many factors determining the size of medical program teams and the inclusion of non-essential personnel. We ask you to be flexible as these factors may prevent us from placing residents based on their preferences.

Please scan all documents and email/mail them to:

ResidentLeadershipProgram@operationsmile.org
Operation Smile
Attn: Sophia Santisi
3641 Faculty Boulevard
Virginia Beach, VA 23453, 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: _____/_____/_____
DAY MONTH YEAR