UNITED STATES CARE NETWORK INFORMATION SHEET

Thank you for your interest in becoming an Operation Smile United States Care Network (USCN) member! Cleft lip, cleft palate and other facial deformities know no geographic boundaries. Many individuals approach Operation Smile looking for resources to help themselves, family members, friends or people they know who might be suffering from lack of access to dental and safe surgical care. U.S Care Network members work within their communities to promote access to safe and affordable care. As a U.S. Care Network member you will be matched, based on your specialty, with inquiries from people within your community wishing to find aid within the U.S. We are accepting dentists, surgeons, pediatricians, and speech pathologists for U.S. Care Network members.

In order to be eligible as a USCN member with Operation Smile, you must fulfill the following criteria:

Basic qualifications:

- Current license
- Current certifications
- At least one year of current experience in specialty applying

If you meet the qualifications above, we will need you to complete an **Application Packet** to become an **Operation Smile United States Care Network Member**. This application packet will be submitted for review by Operation Smile's Medical Oversight Department. Operation Smile will inform you of the results of your application and next steps.

Please submit the following as part of your Application Packet:

- Completed Application
- Completed Questionnaire
- Current Curriculum Vitae/Resume
- Current Licensure
- Copies of diplomas

At Operation Smile 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 Oversight Coordinator at (757) 321-7681 or Monique.Russell@operationsmile.org.

Best regards,

Medical Oversight Coordinator

UNITED STATES CARE NETWORK
MEMBERSHIP APPLICATION

Contact Information

Name	
Street Address	
City ST ZIP Code	
Preferred Phone	
E-Mail Address	
Specialty	

Professional Information

Current Position	
Name of Organization	
Street Address	
City ST ZIP Code	
Work Phone	

Current Work

Briefly describe the nature of your current work.

Interests

Tell us which services you are interested in providing and for what age group.

Credentials

Please attach copies of the following documents:

- Resume
- Diplomas and degrees
- Specialty diploma
- Current license
- Board Certification

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a member I will help break down obstacles to optimal healthcare by providing pro bono or reduced rate services to individuals in the U.S Care patient registry.

Name (printed)	
Signature	
Date	

Thank you for completing this application and for your interest in becoming a member of the USCN.

U.S. CARE NETWORK MEMBERSHIP QUESTIONNAIRE

PURPOSE

The purpose of this questionnaire is to gather information for the USCN membership. This information will be used to ensure that you are properly matched to the services that you are willing to provide.

INSTRUCTIONS

Please fill out this questionnaire in detail.

Which state of the United States do you practice?

Are you willing to provide pro bono services?

Are you willing to provide services at a reduced rate?

What services are you willing to provide?

Do you have an office to provide your services?

Are you affiliated with a hospital/office willing to allow pro bono or reduced rate services?

What age groups are you willing to provide services?