smile network international

Mission Application:

Medical Volunteer

108 West 14th Street • Minneapolis • MN • 55403 • 612.377.1800 • www.smilenetwork.org

December 2017

Dear Medical Applicant:

Thank you for your interest in volunteering with Smile Network. We rely on volunteers to give their time and talent to help bring smile to the faces of children around the world.

Enclosed you will find the volunteer application. Please complete the application and enclose the additional requested information, below. All materials should be sent to the Smile Network office.

- Current CV/Resume
- Current license
- Copies of all diplomas or degrees referenced in your application
- Scanned copy of passport
- 3 Letters of recommendation
- $50 application fee (check or credit card)

Smile Network is unable to process incomplete applications. When we receive your complete application, we will forward it on to our Medical Volunteer Chair for approval. The Chair may call you to clarify information and will determine the status of your application. The process may take up to 8 weeks.

Smile Network will inform you of the results of your application via mail. Upon approval by the Medical Chair, you will be entered into the Smile Network Medical Volunteer database and will be eligible to participate in upcoming missions. Mission selections are done at the discretion of Smile Network, but mission teams are comprised of experienced Smile Network Medical Volunteers, newly approved Medical Volunteers and Non-Medical Staff or Volunteers.

We look forward to hearing from you soon.

Please feel free to contact us at 612.377.1800 or via email at rachael@smilenetwork.org

Kind Regards,

Kim Valentini

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Mission Application: Medical

Contact Information

Name _____ D.O.B._____/_____/_____

Home Address _____

City _____State _____ Zip _____

Home Phone _____Work Phone _____

Cell Phone _____ Email _____

Passport # _____Country of Issue _____ Exp _____/_____/____

Emergency Information

Emergency Contact _____ Relationship _____

Address _____

Daytime Phone _____Evening Phone _____

Medical Insurance Plan _____ Member # _____

Allergies _____ Blood Type _____

Current Medications _____

Medical conditions we should know about: _____

_____

Other

Languages spoken fluently (in addition to English) _____

Would you be available for a 10-day mission: Yes _____ No _____

8-day mission: Yes _____ No _____

How much notice do you require in order to travel on a mission? _____

Do you have medical mission experience? If so, please detail the organization, experience, and your role. _____

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Mission Application:
Medical

How did hear about Smile Network? _____

_____

_____

Why are you interested in volunteer with a Smile Network medical mission team?

_____

_____

_____

_____

What skills and attributes will you bring to a mission team?

_____

_____

_____

_____

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Mission Application: Medical

Employment Information

Occupation _____ Place of Employment _____

Work Address _____ City _____

State _____ Zip _____ Phone _____

Position/Title _____ Dates of Employment _____

Experience

Smile Network is committed to staffing missions with experienced and qualified volunteers. For this reason, only those experienced and credentialed in one of the following positions will qualify. Please check which best describes your experience.

Pediatrician _____ Registered Nurse / CST _____

Surgeon _____ Anesthesia Provider _____

Please indicate the patients you have had experience with in the last 3-5 years:

Pediatrics (0-6 yrs) _____ Youth (7-14 yrs) _____ Adult (14 and over) _____

Specialty

Please fill out only the section that pertains to your stated specialty, below.

Nursing

Which area do you feel you are most qualified?

Operating Room: ____ Recovery Room: _____ Pre/Post Op.: _____

Pediatrics

Board Certification in pediatrics: Yes _____ Date: _____ No _____

Board Certification in pediatric critical care: Yes _____ Date: _____ No _____

Do you currently practice in your stated specialty? Yes _____ No _____

Anesthesia

Board Certification : Yes _____ Date: _____ No _____

Board Eligible: Yes _____ Date: _____ No _____

Do you still practice in your stated specialty? Yes _____ No _____

Please provide details and dates of pediatric fellowships you have completed:

Anesthesia Provider (continued)

Specialty Training	School/Hospital
Cleft Lip	
Cleft Palate	
Burns	
Flaps	
Microsurgery	
Pediatric Anesthesia	
Other	

Surgeon

Board Certification: Specialty _____ Date _____/_____/_____

Board Eligible: Specialty _____ Date _____/_____/_____

Do you currently practice in your stated specialty? Yes _____ No _____

Are you affiliated with a cleft center? Yes _____ Name _____ No _____

Specialty Training	School/Hospital	Dates	Degrees
Cleft Lip			
Cleft Palate			
Burns			
Flaps			
Microsurgery			
Pediatric Anesthesia			
Other			

How many cleft lip surgeries have you done in the last year? _____ Cleft palates? _____

In the last 5 years? _____ _____

In your surgical career? _____ _____

Would you be comfortable performing at your own table with good to excellent results?

Yes _____ No _____ Explain _____

Authorization for Release of Criminal History

TO: BCA/Department of Records

RE: Data Request for:

First Name _____ Middle_____ Last _____

Maiden, Alias or Former Name _____

Date of Birth _____/_____/_____ Social Security Number _____

Gender: Female Male

Applicant History

Have you ever been convicted of a misdemeanor or felony? Yes _____ No _____

Description of Offense _____

Date of Offense _____ Location of Offense _____

This is full and sufficient authorization, pursuant to Minnesota Statue 13.05, Subd.4, to release to:

SMILE NETWORK INTERNATIONAL
108 W 14th St., Minneapolis, MN 55403

All Criminal History Record Information maintained by your agency, without exception. This information is being released for the purpose of acting as a volunteer due to possible involvement with vulnerable minor children. This information will be confidential.

The expiration of this information shall be for a period no longer than three years from the date of my signature.

_____ _____

Signature of Applicant **Date**

Notarization is Required
Please have this form notarized before you return it to Smile Network International.

State of _____, County of _____

Signed, sworn and acknowledgement before me this

_____ day of _____, 20_____

Completion of Application

Thank you for completing the Medical Volunteer Application!

Special Note on Mission Participation:

If you are selected for a mission, all of your work will be done on a volunteer basis. Smile Network covers the cost of airfare, in-country transportation, double occupancy lodging, and some meals for volunteers during missions. To make this possible, Smile Network requires each team member to pay a team fee that will vary by location (ranging from $600-$1000). Your $50 application fee check will be cashed when your application is received.

The following are responsibilities of the volunteer:

- Additional fees for Business Class ticketing or any airfare upgrades/airline changes
- Additional fees for different outbound or return dates of mission travel
- Cost of immunizations and medications needed for travel on missions
- Travel insurance, if you choose to purchase
- Hotels are booked double occupancy. If you select a single room, which may be available at some mission sites, you are responsible for covering 100% of the cost of the room.

Please send your completed application and attachments to the address, below, or send a fax to 612.659.4443. Please allow 6-8 weeks for application processing. Smile Network will notify you of the results of your application. Please contact Smile Network International (612.377.1800) if you have questions regarding your application.

Smile Network International
Attn: Kim Valentini
108 West 14th Street
Minneapolis, MN 55403

Fax: 612.659.4443