Volunteer Application

Medical

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

March 15, 2023

smile :)
network international

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 smiles to the faces of children around the world.

Enclosed you will find the volunteer application. Please complete the application and return the additional requested information listed below. All materials should be sent to the Smile Network office, 108 West 14th Street, Minneapolis, MN 55403 or scanned to info@smilenetwork.org.

- Current CV/Resume
- Current license
- Copies of degrees / licenses referenced in your application
- Scanned copy of driver's license or passport
- 3 Letters of recommendation
- $50 application fee (check or credit card)
- Notarized Authorization for Release of Criminal History

Smile Network is unable to process incomplete applications. When we receive your complete application, we will forward it on to our SNI Medical Committee, for approval. The SNI Medical Committee may call you to clarify information and will determine the status of your application. The process may take up to 4 weeks.

If your application is approved, you authorize Smile Network International to share the following information with Smile Network Medical Campaign Partners:

- Copies of your CV,
- A copy of your driver's license or passport,
- And a copy of your degree(s)/license(s).

Further, while the specific results of your criminal background check will not be shared with Smile Network Medical Campaign Partners, the fact that you successfully completed the criminal background check will be shared.

Volunteer Medical Campaign selections are done at the discretion of Smile Network. Smile Network will inform you of the results of your application via mail. Upon approval, your application fee will be deposited, and you will be entered into the Smile Network Medical Volunteer database and will be eligible to participate in upcoming campaigns.

We look forward to hearing from you soon. Please feel free to contact us at 612.377.1800 or via email at info@smilenetwork.org

Kind Regards,

Kim Valentini
Founder, Smile Network International

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CONTACT INFORMATION

Name ____

D.O.B.______/________/________ Preferred Pronouns _________________________

Position Applying for (check):

Surgeon	Pediatrician	Anesthesia Provider	
Ward Nurse	PACU Nurse	OR Nurse	Medical Records

Home Street Address

____

City ______________________________State _________________Zip ______________

Cell Phone _________________________ Work Phone_____________________________

Email ____

Passport # __________________Country of Issue _______________ Exp _____/_____/____

Medical Insurance Plan _____________________________ ___Member # _______________

Allergies ____ Blood Type ______________

Current Medications ____

Medical conditions we should know about

____

Emergency Information

Emergency Contact

____Relationship __________________

Street Address ____

City ______________________________State _________________Zip ______________

Daytime Phone ________________________Evening Phone ____________________________

Other

Languages spoken fluently (in addition to English) ________________________________

Would you be available for a 10 day campaign Yes No

8 day campaign Yes No

How much notice do you require in order to travel on an International Surgical Campaign?

____

Do you have International Surgical Campaign experience? If so, please detail the organization, experience and your role.

____

____

____

Name of person at SNI who referred you ________________________________

Phone number of referral ________________ Email of referral ________________

How did hear about Smile Network? ________________________________

____

____

Why are you interested in volunteering with a Smile Network International Medical Campaign team?

____

____

____

____

What skills and attributes will you bring to an International Medical Campaign team?

____

____

____

____

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EMPLOYMENT INFORMATION

Occupation ___________________________Place of Employment ___________________________

Work Address _____________________________________ City ___________________________

State ______________________ Zip _______________ Phone ______________________________

Position/Title ______________________________________ Dates of Employment _____________

EXPERIENCE

Smile Network is committed to staffing Medical Campaigns 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.

Surgeon　Pediatrician　Anesthesia Provider

Ward Nurse　PACU Nurse　OR Nurse　Medical Records

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)

Do you have these certifications?　PALS Certification　Exp________________________

ACLS Certification　Exp ______________________

Specialty

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

Nursing

Which areas do you feel you are most qualified?

Operating Room　Recovery Room　Pre/Post Op:

License Number ________________________________ Expiration Date ______/______/______

Pediatrics

Board Certification in Pediatrics　Yes　Date ______________　No

Board Certification in Pediatrics Critical Care　Yes　Date ______________　No

License Number ________________________________ Expiration Date ______/______/______

Do you currently practice in your stated specialty?　Yes　No

Anesthesia

Board Certification　Yes　Date ______________　No

Board Eligible　Yes　Date ________________　No

License Number ___________________________________Expiration Date ____/______/______

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Anesthesia Provider (continued)

Do you still practice in your stated specialty? Yes No

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

____

____

Have you previously provided anesthesia for cleft lip / palate procedures? Yes No

If yes, please describe

____

____

Surgeon

Board Certification Specialty ______________________________ Date ______/______/______

Board Eligible Specialty ______________________________ Date ______/______/______

License Number __________________________________ Expiration 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	Additional Info (optional)
Cleft Lip			
Cleft Palate			
Burns			
Flaps			
Microsurgery			
Other			

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

How many cleft lip surgeries have you done in the last 5 years? __________ Cleft palates? __________

How many cleft lip surgeries have you done in your surgical career? _______Cleft palates?__________

Please provide details and dates of fellowships you have completed:

____

____

How long does it take to perform your standard lip / palate operation?

SNI Background Check Policy and Applicant History

BACKGROUND CHECK POLICY

Smile Network International ("SNI") requires that all volunteers satisfactorily complete a criminal background check and disclose any history of offenses. SNI completes a criminal background for all volunteers using data from the State of Minnesota Bureau of Criminal Apprehension ("BCA") or the Bureau in the state in which the volunteer resides at the time of the application. A BCA criminal background check provides the following information about adults:

- Conviction data for 15 years after discharge of sentence.
- Sentence information for 15 years after discharge of sentence.
- Confinement information for 15 years after discharge of sentence.

SNI reviews all criminal background check reports to determine whether a volunteer is approved to participate in SNI missions and campaigns. Volunteers with the following types of convictions are disqualified from participation:

- Felony-level convictions involving crimes against a person including, but not limited to homicide, assault, domestic assault, criminal abuse and/or neglect, and sex crimes;
- Felony-level convictions involving drug offenses;
- Crimes involving children, regardless of the level of offense.

SNI does not share the actual criminal background check report with any outside parties, but rather certifies that any volunteer who is cleared to participate in SNI missions and campaigns has successfully completed the background check process, in accordance with SNI's background check policy. This is to protect volunteer privacy.

APPLICANT HISTORY

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

Description of Offense

____

____

____

Date of Offense ______________________ Location of Offense ______________________

Authorization for Release of Criminal History

Date ______________

The following named individual has made application with Smile Network for volunteering.

First Name _________________________ Middle___________________ Last ______________________________

Maiden, Alias or Former Name

____

Date of Birth _________/__________/_________ Social Security Number _____________________

Gender

Man Woman Transgender Non-Binary/ Non-Conforming Prefer Not to Respond

Notification

The volunteer position for which I am being considered requires me to consent to a criminal background check as a condition of volunteering. This check includes the following: criminal history reference searches for felony and misdemeanor convictions in the State of Minnesota.

Authorization

I hereby authorize **Smile Network International (SNI), 108 W 14th St., Minneapolis, MN 55403** to conduct the criminal background check described above. In connection with this, I also authorize the use of the Minnesota Bureau of Criminal Apprehension to assist SNI in collecting this information.

I also am aware that records of convictions are not an absolute bar to volunteering. Such information will be used to determine whether the results of the background check reasonably bear on my trustworthiness or my ability to perform the duties of my volunteer position in a manner which is safe for SNI's organization, its partners, and the patients they serve. I understand that the results of the criminal background check will be kept confidential to the extent possible. However, the SNI Founder, SNI Medical Committee Chair, and SNI Legal Committee Chair may learn the results of my criminal background check in order to determine my fitness to volunteer for the organization. These individuals are required to maintain confidentiality of all volunteer criminal background check information. Further, SNI will not disclose the results of my criminal background check to external third parties.

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_________

My commission expires _______________________________________

Thank you for completing the Volunteer Medical Application!

Special Note for Volunteer Medical Participation:

If you are selected for a Volunteer Medical Campaign, all of your work will be done on a volunteer basis. Smile Network and our partners cover the cost of transportation, double occupancy lodging, and some meals for volunteers during the Campaigns. To make this possible, Smile Network requires each team member to pay a team fee that will vary by location (ranging from $600-$1,000).
Your $50 application fee will be processed when your application is approved.

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 Campaign travel
- Cost of immunizations and medications needed for travel
- Travel insurance, if you choose to purchase
- Hotels are booked double occupancy. If you select a single room, where available, you are responsible for covering 50% of the cost of the room.

Please send your completed application and attachments to the address below or scan them to info@smilenetwork.org, Please allow 4 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