ALLIANCE FOR SMILES INTERNATIONAL, INC.
Application for Medical Volunteer

□ Plastic Surgeon □ Anesthesiologist □ CRNA □ Pediatrician □ OR Nurse
□ PACU Nurse □ Dentist □ Dental Hygienist □ Speech Pathologist

The following documents must be included with this application:

- *Current License to Practice (CRNAs: include RN & CRNA licenses)*
- *Curriculum Vitae*
- *PALS Certification (for Pediatricians and PACU Nurses)*
- *Diploma*
- *Board Certification (for Surgeons, Anesthesiologists, CRNAs and Pediatricians)*
- *Cover Letter (Surgeons: include cleft experience; Anesthesiologists: include pediatric experience; PACU Nurses: include pediatric experience; Dentist: include pediatric experience.)*
- *Photocopy of Passport*

Send all documents to: **Alliance for Smiles**
2565 Third Street Suite 237
San Francisco, CA 94107

PERSONAL INFORMATION		
Last Name:	First Name:	Middle Name:
Any other name under which you have been known? Name(s):		
Home Address:	City:	
	State:	Zip:
Home Telephone Number: ( )	Cell Phone Number: ( )	
E-mail:	Second E-mail :	
Birth Date:	Male ☐	Female ☐
Complete name as shown on Passport:	Nationality:	
Passport Number:	Date of Expiration:	
Emergency Contact:	Emergency Contact Telephone Number: ( )	

PRACTICE INFORMATION		
Physician, Dentist or Allied Health Practitioner affiliated with (if applicable):		
Area of Specialty:		
Office Address:	City:	
	State:	Zip:
Telephone Number: ( )	Fax Number: ( )	

GENERAL INFORMATION

Alliance for Smiles has made a long-term commitment to treating cleft anomalies in under-served areas of the world. Are you interested in making a similar commitment?

Alliance for Smiles will cover international travel costs for medical volunteers. Each volunteer is required provide their own transportation to and from the US point of exit (usually San Francisco or Atlanta). Volunteers are also required to pay a tax deductible $350 Mission Participation Contribution, and a $30 Travel Health Insurance Fee. . Do you agree to do so?

Do you speak any languages besides English? Are you fluent?

Prior medical missions you have gone on:

Are you a Rotarian? If so, how long? Club name/location & District:

Do you have any medical conditions we should be aware of? (attach additional sheets if needed)

Do you take prescribed medications? (optional)

There will be times when you will be asked to wear an Alliance for Smiles t-shirt or polo shirt that will identify you as a team member. Please indicate your shirt size (in men's sizes):

PROFESSIONAL REFERENCES

LIST TWO PROFESSIONAL REFERENCES, PREFERABLY PHYSICIANS, DENTIST OR ALLIED HEALTH PRACTITIONERS WHO ARE FAMILIAR WITH YOUR WORK. IF POSSIBLE, INCLUDE AT LEAST ONE MEMBER FROM THE MEDICAL STAFF OF EACH FACILITY AT WHICH YOU HAVE PRIVILEGES:

REFERENCE # 1

Name of Reference:	Title:	Telephone Number:
Address:	City:	
	State:	Zip:

REFERENCE # 2

Name of Reference:	Title:	Telephone Number:
Address:	City:	
	State:	Zip:

ATTESTATION QUESTIONS

Please answer the following questions YES or NO.
If your answer to any question is YES, please provide full details on a separate sheet.

1. In the past three years, has your professional license been terminated, stipulated, restricted, limited, conditioned, suspended, evoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. Is your professional license or registration currently being investigated?

3. In the past three years, has your DEA registration been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

4. In the past three years, has your membership, participation, clinical privileges, or employment been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. In the past three years, have you voluntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

ATTESTATION QUESTIONS (Continued)

Please answer the following questions YES or NO.

If your answer to any question is YES, please provide full details on a separate sheet.

6. In the past three years, have you involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration?

7. In the past three years, has your membership or fellowship in any professional organization or your specialty board certification been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. In the last three years, have you been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, Hospital, medical staff, or any health-related agency or organization?

9. In the past three years, has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. Are there any charges pending or are you currently charged with or have you been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offense, in the past three years?

11. In the past three years, have you been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment with a patient?

12. In the past three years, have you had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? If yes, please complete the enclosed Malpractice Litigation or Professional Complaints Addendum. You may be asked for additional information by individual organizations.

13. In the past three years, has your professional liability carrier refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. In the past three years, have you practiced medicine without professional liability insurance?

15. Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

16. Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

17. Are you currently using illegal drugs?

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSIONS FROM THIS APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR AFFILIATION WITH ALLIANCE FOR SMILES INTERNATIONAL, INC. I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED TO ALLIANCE FOR SMILES INTERNATIONAL, INC. IN THIS APPLICATION AND IN ANY ACCOMPANYING DOCUMENT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Print Name: _____

Signature: _____ Date: _____

Note: All volunteers must get vaccinated for hepatitis A and B before participating in a mission.

MALPRACTICE LITIGATION AND PROFESSIONAL COMPLAINTS	
If you answered Yes to disclosure #12, please complete the following form. For each lawsuit or complaint, please furnish the following information and **attach a copy of the complaint including your response to the complaint and level of participation.** It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.	
Name(s) of Plaintiff(s) or complaint(s):	
Month/Year of Incident:	
Where incident occurred?	
Describe the nature of incident (complaint, allegation):	
Provide a narrative description of your participation/level of care:	
Outcome of incident: Pending _____ Dropped/Settled/Closed-no payment _____ Dropped/Settled/Closed/with payment, amount $ _____ Verdict for you, no payment _____ Verdict for plaintiff, amount $_____ Dismissed with prejudice, amount $_____ Dismissed without prejudice, amount $_____	
Represented by legal counsel for this claim/malpractice lawsuit?	
Yes:	No:
Name:	
Address:	
Phone Number:	

Insurance company that provided coverage for this claim:	
Name:	
Address:	
Phone Number:	Policy No.