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**International Medical Fellowship Application**

*The following documents must be included with this application:*

* *Cover Letter and Resume (Please include your international and medical experience, if any.)*
* *A video of yourself telling us why you would be a great asset to our team and how you heard about AfS.*
* *Screen shot of the receipt (Pay deposit of $500 at allianceforsmiles.org to hold your place. Deposit is fully refundable until 60 days in advance.)*

**Email:** [**alison@allianceforsmiles.org**](mailto:alison@allianceforsmiles.org)

**or**

**Mail all documents to: Alliance for Smiles**

**2565 Third Street Suite 237 San Francisco, CA 94107**

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| **BASIC INFO** | | | | | | | | | | | | | | |
| Last Name: | | First Name: | | | | | | | Middle Name: | | | | | |
| Any other name under which you have been known? Name(s) | | | | | | | | | | | | | | |
| Home Address: | | | | | | | | City: | | | | State: | | Zip: |
| Home Phone Number: | | | | Cell Phone Number: | | | | | | | | | | |
| Temporary Address (if different from the above) | | | | | | | | City: | | | | State | | Zip: |
| Email: | | | | Second Email: | | | | | | | | | | |
| **ADDITIONAL INFO** | | | | | | | | | | | | | | |
| Birthdate (MONTH/DD/YYYY): | | | | | | | | | | | | | | |
| Sex as shown on travel documents (Passport, etc): | | | | | | | | | | | | | | |
| School Name (if applicable): | | | | School Year In The 2017-2018 Academic Year (If applicable): | | | | | | | | | | |
| Please describe your language skills: | | | | | | | | | | | | | | |
| 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): You will need a minimum of 2 sets of scrubs. You may use some of ours by emailing [Yulla@allianceforsmiles.org](mailto:Yulla@allianceforsmiles.org), or you may purchase your own. | | | | | | | | | | | | | | |
| **PERSONAL REFERENCE #1 (non-family member, someone who has known you for at least 5 years)** | | | | | | | | | | | | | | |
| Name: | Title: | | Telephone #: | | | Email: | | | | | | | | |
| **PROFESSIONAL REFERENCE #2** | | | | | | | | | | | | | | |
| Name: | Title: | | Telephone #: | | | Email: | | | | | | | | |
| **GENERAL HEALTH** | | | | | | | | | | | | | | |
| Please describe your current health status, including any issues which may affect your ability to perform on a medical mission (attach additional sheets if needed): | | | | | | | | | | | | | | |
| Please list any allergies you have experienced: | | | | | | | | | | | | | | |
| Please list any medications you are currently taking: | | | | | | | | | | | | | | |
| Emergency contact’s name and relationship  #1 | | | Phone number:  #1 | | | | | | | Email:  #1 | | | | |
| #2 | | | #2 | | | | | | | #2 | | | | |
| **PARENT OR GUARDIAN INFO #1** | | | | | | | | | | | | | | |
| First Name: | | Last Name: | | | | | | | Role (mother, father or guardian?): | | | | | |
| Address (if different from participant): | | | | | | | City: | | | | State: | | Zip: | |
| Home Phone Number: | | Cell Phone Number: | | | | | | | Work Phone Number: | | | | | |
| Email Address #1: | | | | | Email Address #2: | | | | | | | | | |
| **PARENT OR GUARDIAN INFO #2** | | | | | | | | | | | | | | |
| First Name: | | Last Name: | | | | | | | Role (mother, father or guardian?): | | | | | |
| Address (if different from participant): | | | | | | | City: | | | | State: | | Zip: | |
| Home Phone Number: | | Cell Phone Number: | | | | | | | Work Phone Number: | | | | | |
| Email Address #1: | | | | | Email Address #2: | | | | | | | | | |

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.

I ALSO AFFIRM THAT I AM IN GOOD HEALTH AND ABLE TO WORK LONG HOURS, LIFT UP TO 50# AND DO NOT HAVE ANY KIND OF ILLNESS OR LIMITATION THAT WOULD CAUSE ME NOT TO PARTICIPATE DURING OUR INTERNSHIP DATES.

Print Name:

Signature: Date:

**Notes: This document must be signed by legal guardian if under 18 years of age. All interns must get vaccinated for hepatitis A and B before participating in a mission.**