



INTERNATIONAL OUTREACH PROGRAM

A Partnership of the American Burn Association and Children's Burn Foundation

VOLUNTEER APPLICATION		
PERSONAL DATA		
Name:		
Current address:		
City:	State:	Zip:
Work Phone:	Home Phone:	Cell/Pager:
Fax:	Email:	
Date of birth:	Citizenship:	
Profession:	Specialty:	
Current Professional Status & Institutional Affiliation (academic, hospital, private practice, retired, etc.)		
Other Relevant Teaching/Clinical Experience		
State(s) in which you hold valid licenses/registration:		Board certified/eligible?
License #(s):		<input type="checkbox"/> Yes <input type="checkbox"/> No Year_____
Have you ever had a professional license revoked/suspended/limited/ conditioned or not renewed by any licensing board or any health-related agency organization, or is there a review pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
Have you ever 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation) or other offense? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment with a patient, co-worker, or other? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
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 health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		

VOLUNTEER APPLICATION

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?

Yes No If yes, please explain.

Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Yes No If yes, please explain.

EDUCATION

Undergraduate: (Institution, Degree, Date, Area of Study)

Graduate: (Institution, Degree, Date, Area of Study)

Graduate: (Institution, Degree, Date, Area of Study)

Additional Education: (Institution, Degree, Date, Area of Study)

Internship/Residency: (if applicable)

PROFESSIONAL AFFILIATIONS

Please list all professional affiliations.

PROFESSIONAL REFERENCES

This section must be completed to initiate volunteer placement. We encourage you to include the email address of your references if possible. Also, please notify your references so they are aware that they might be contacted by a representative of the American Burn Association.

1) Name:		Work Phone:
Title/Institution:		Home Phone:
Address:		Cell/Pager:
City:	State/Zip:	E-mail:
2) Name:		Work Phone:
Title/Institution:		Home Phone:
Address:		Cell/Pager:
City:	State/Zip:	E-mail:

VOLUNTEER APPLICATION

3) Name:		Work Phone:
Title/Institution:		Home Phone:
Address:		Cell/Pager:
City:	State/Zip:	E-mail:

EXPERIENCE

Please list all prior international experience.

Country:	Date:	Sponsor:
Country:	Date:	Sponsor:
Country:	Date:	Sponsor:
Country:	Date:	Sponsor:
Country:	Date:	Sponsor:

AVAILABILITY

The amount of time I can volunteer would be (check largest possible number)

2 weeks
 1 month
 3 months
 6 months
 9 months
 12 months

Date preferred: _____ Alternative dates: _____

LOCATION

Specific region(s) or country of preference:

Not willing to serve in:

COMPANIONS

I wish to be accompanied by

Spouse (list name)
 Children (list ages)
 Other (list name)

Would your companion be interested in serving in a volunteer capacity?
 Yes
 No
 If yes, in what capacity?

EMERGENCY

Name:	Relationship:
Address:	Work Phone:
City, State, Zip:	Home Phone:
Email:	Cell/Pager:

OTHER

How did you hear about the American Burn Association International Outreach Program?

Completion of this form is the first step in the placement process and does not guarantee assignment. Depending on the specific requirements of each site you may be asked to submit additional documentation in order to continue the placement process.

VOLUNTEERING WITH AMERICAN BURN ASSOCIATION & CHILDREN'S BURN FOUNDATION

Briefly indicate why you are interested in volunteering with ABA/CBF.

VOLUNTEER APPLICATION

Volunteers will demonstrate the highest standards of professional and personal conduct at all times. Sensitivity to cultural and social beliefs and practices of the host country should guide professional and personal behavior.

Signature of applicant:

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

***There will be a \$60 processing fee for applicants selected for medical missions. The fee covers the expense of a background check.*

Date:

Please send this form to:

This form will be considered valid for three years from the date submitted.

For Office Use Only

Info Sent

Referred to

Assignments