Glens Falls Medical Mission Foundation

PROJECT GUATEMALA
www.gfmmf.org

VOLUNTEER APPLICATION AND AGREEMENT

Name (please print): ____ Date of Birth: ______________

Address: ____

Phone: Home (_______) ______________________ Work (______) _________________________

Cell (_______) _________________ E-mail ____

Preference: Spring Mission ____ Fall Mission ____ Either Mission ____

Occupation/Profession ____

Are you in good health? Yes ____ No ____

What position are you applying for (Please Check) :

*Medical Provider** _______ *What clinics would you be willing to work in?

General Medicine________ Womens Care/GYN __________ Pediatrics _________

Pharmacist or Pharmacy Tech _____- *Dental Provider* ____ - *Nurse* ____ - *Translator*____

- *ATV (All Terrain Volunteer - which is a general helper)* _______ *Other*__________________

If applying as an **ATV**, indicate your area(s) of interest (we will train you): Vision Refraction ____

Crowd Control ___ - Fluoride Applications ___ - Teaching Tooth-brushing ____-

Assisting in Pharmacy ___ - Education ____ - General Assisting ____

Health Care Provider Degrees (Check): MD ___ - DO___ - DDS___ - PA___ - NP___ -

RN ____ LPN ___ - R Ph___ - PT___ - OT ___ - DPM ___ - Other __________________

Please submit a copy of your medical license with this application.

Are you a student* in any of these areas? If so, which one? ______________________________

* Along with this application, please submit a written statement from your school
attesting to the fact that you are a student in good standing,
and indicating whether you will be getting credit for this experience.

How well do you speak Spanish? Fluent ____ Some ____ None ____

Do you speak Spanish fluently enough to be a translator? Yes ____ No _____

If you are a provider, can you speak Spanish well enough to do a medical history or physical exam without a translator? Yes ____ No ____

Do you have Red Cross certification in: CPR ____ First Aid ____ ALS ____ PALS ____
Other ____

Do you have instructor certification in any of the previously mentioned areas? If so, which one(s)?
____

Do you have any particular knowledge, skills, experiences, or connections to other people relevant to this mission? Do you have any special talents or expertise that would enhance your mission experience? ____

____

Have you been with us before? Yes ______ No ______

Please list any previous medical mission work, or related experiences.

____

____

Do you have a valid passport? Yes ____ No, but I will get one if selected ____

Please enclose a legible copy of the first two inside pages of your passport with this application. We must be able to read your passport number.

Have you ever been convicted of a crime? Yes ____ No ____ If Yes, please describe fully the criminal conviction(s) or findings. A conviction record will not necessarily be a bar to participation.

____

Will your participation as a volunteer on the medical mission, if accepted, be contingent on the acceptance of another person such as a spouse, child, friend, co-worker, etc? Yes ____ No ____

If yes, what is the name of that person? ____

Has that person submitted an application yet? Yes ____ No ____

Name(s) of team member(s) you would like to share accommodations with at:

El Puente Hotel in Cuilapa (week of mission) ___________________________________

____

Team T-Shirt: Please indicate the size you would prefer. S ___ M ___ L ___ XL ___ XXL ___

Do you have a food preference? No ____ Vegetarian ____ Other – please describe

____

We will do our best to see that your food preferences are provided, if possible. We cannot necessarily accommodate severe food allergies

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I, the undersigned, have read, fully understand, and hereby agree to comply with the rules, regulations and requirements presented and explained within the accompanying Volunteer Agreement. I represent that I have the professional or other training necessary for me to adequately and safely fulfill my identified role on the mission. Further, I, for myself, my estate, my heir's and successors, hereby covenant and agree to hold the Glens Falls Medical Mission Foundation, Inc., its officers, directors, members, agents and employees harmless and to indemnify them from any and all liability for injury, loss, claims or damages from any cause to person or property arising out of my involvement in the mission, all actions and travel related to the mission and conduct in connection with the mission, regardless of negligence.

____ ____________________

Signature Date

____ ____________________

Parent's Signature if a Minor Date

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MEDICAL APPLICATION

Name (Please Print) ____

Complete and sign this form. Return it with the Volunteer Application, a copy of your passport and a copyof your medical license, if applicable. Please mail to: GFMMF, PO Box 627, Glens Falls, NY 12801-0627.

Required vaccines:

Note: **These immunizations are mandatory for participation**. If you have not had them, do so promptly and inform us of the dates once you have had the vaccines.

Tetanus *(within the last 10 years – preferably only 7-8 years)* Yes _____ No _____ If yes, what is the date of your last Tetanus shot: _____________ **If no**, **get the vaccine promptly**.

Hepatitis B series Yes ____ No ____ *(series of 3 injections – initial and then at 1 month and at 6 months – get at least the first two – you can get the final injection at the next 6-month mark)*
If yes, dates of Hep B series: __________________, __________________, __________________

Hepatitis A series Yes ____ No ____ *(initial injection with a booster in 6 months – get at least the initial injection – you can get the booster later at the 6-month mark)*
If yes, dates of Hep A series: __________________, __________________

Have you ever had any surgery? If so, please state when and what the surgery was for:
____
____
____

Do you have any medical conditions or physical limitations the mission should know about?
____
____

Are you allergic to any foods, medications or environmental substances? If so, please list:
____
____

Any comments or concerns?
____
____
____
____

Most recent BP ________/________ Weight ___________

Please list your **current active health problems and treatments**. This would include, but not be limited to such conditions as high blood pressure, diabetes, heart disease, bipolar disorder, etc. Include any physically handicapping conditions. *Use the back or attach another page if necessary.*

Disease or disorder: **Current Treatment:**

drug strength frequency

1. ____
2. ____
3. ____
4. ____
5. ____

Please list any other medications, supplements, herbals, etc. that are not included above.

____

____

____

____

In case of emergency, notify:

Name: ____

Address: ____

Telephone: _____________________________ Email: _________________________________

I have provided accurate information on my current health condition.
I understand and accept the possible medical risks of participating in this mission.

____ ____________________

Signature Date

____ ____________________

Parent's Signature if a Minor Date

CONSENT FOR MEDICAL TREATMENT

I hereby agree to the performance of any emergency medical treatment, anesthetics and/or operations deemed necessary by an attending physician on:

____

Print name of applicant

I realize this authority is being granted for domestic and non-domestic territory only while volunteering on this medical mission. I understand that I am responsible for providing medical and accident insurance to cover activities while participating in any Glens Falls Medical Mission Foundation program, PROJECT GUATEMALA.

____ _____________________

Signature of applicant (or parent/legal guardian, if a minor) Date

Revised May, 2015