

Office Use Only
TB__ DB__ QBS__ EML1__ EML2__

Office Use Only
Name: _____
Specialty: _____

MEDICAL MISSION TEAM VOLUNTEER APPLICATION



PO Box 273, Palm City, FL 34991
Phone (772) 221-4688
Fax (772) 600-1941
www.lightoftheworldcharities.com

(Please Print Clearly)

Date: _____

NAME: _____
Last First Middle

ADDRESS: _____
Street City ST ZIP

PHONE: _____
Home Business Cell

DATE OF BIRTH: _____ CITIZENSHIP _____ E-mail: _____

PROFESSIONAL TITLE: _____ AREA OF SPECIALTY _____

Please attach a current resume (if you already have one), listing your work experience, educational background etc. **Please attach a legible copy of your license, certification, diplomas and a "colored" copy of your passport. Physicians must submit diplomas from medical school and your school of surgical specialty!** Please feel free to scan and email documentation to LOTWC1@comcast.net

REFERENCES: (Professional and Character):

1. Name: _____
Phone, Address and Title: _____

1. Name: _____
Phone, Address and Title: _____

1. Name: _____
Phone, Address and Title: _____

ARE YOU FLUENT IN ANY OTHER FOREIGN LANGUAGES? _____
WHICH? _____

PREVIOUS COMMUNITY EXPERIENCE: _____

PREVIOUS OVERSEAS VOLUNTEER EXPERIENCE: _____

TRAVEL EXPERIENCE: _____

RELIGIOUS AFFILIATION: _____

MEDICAL HISTORY:

HEART OR LUNG PROBLEMS (ASTHMA): _____

DIABETES: _____

HIGH BLOOD PRESSURE: _____

ALLERGIES: _____

OTHER: _____

MEDICATIONS: _____

IN CASE OF AN EMERGENCY NOTIFY: _____

RELATIONSHIP _____ PHONE # _____

HOW DID YOU HEAR OF LIGHT OF THE WORLD CHARITIES? _____

WHY WOULD YOU LIKE TO BE A MEDICAL TEAM VOLUNTEER? _____

ARE YOU WILLING TO ACCEPT THE RESPONSIBILITY FOR PREPARING FOR THIS PROJECT PRIOR TO DEPARTURE AND WHEN WOULD YOU HAVE THE TIME TO DO SO?

I am willing to travel to the following countries:

___ Africa (1/2 trip expenses are my responsibility) ___Haiti ___Honduras ___Nicaragua

I am able to participate on more than one mission trip per year. _____ YES _____ NO

I have worked in the OR for _____years

I have scrubbed for _____years.

I have circulated for _____years.

I have worked Recovery Room or ICU for _____years.

I am CNOR certified Yes___ NO_____.

I have other certifications which include: _____

I have worked in the area of my specialty, which is _____ for _____ years.

I hereby affirm that the above information is accurate and complete,

Signature _____ Date _____

Questions/Comments? _____
