



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:
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Work Phone:	Home Phone:	Cell/Pager:
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Fax:	Email:	
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Date of birth:	Citizenship:	
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Profession:	Specialty:
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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: License #(s):	Board certified/eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No Year_____
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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?
Yes 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Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?
Yes 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?
Yes 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?
Yes 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?
Yes 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?
Yes No If yes, please explain.

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

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.

I hereby give the Children's Burn Foundation permission to conduct a background check including verification of employment, address and criminal background.

***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: Program Director
Children's Burn Foundation
5000 Van Nuys Boulevard
Suite 450
Sherman Oaks, CA 91403

Fax: 818-501-4005
Or email a scanned copy to tsorkin@childburn.org

For more information about the program, please contact CBF at 818-907-2822. Thank you for your interest!

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

For Office Use Only

Info Sent

Referred to

Assignments