Operation Smile
Changing Lives One Smile at a Time

Dear Child Life Applicant:

Thank you for your interest in becoming an Operation Smile Child Life Specialist Volunteer! As you know, Operation Smile relies on volunteers to give their time and expertise to help bring smiles to the faces of children at home and around the world.

Enclosed you will find a volunteer application. To help expedite the application process, please submit the completed application along with:

- Current Curriculum Vitae/Resume
- Current CCLS certification (if applicable)
- Copies of diplomas

Please do not send incomplete application packages. Upon receipt of your complete application packet, it will be forwarded to the Operation Smile Child Life Council for review. The Child Life Council may telephone you to clarify information and will determine the status of your application. This process can take up to 8 weeks.

Operation Smile will inform you of the results of your application. Upon approval by the Child Life Council, an applicant will be entered into the Operation Smile Medical Volunteer database, indicating eligibility to participate on a medical mission. Mission selection guidelines state that all mission teams are to be comprised of at least 50 percent experienced Operation Smile team members and the remainder of the team of new volunteers.

We look forward to hearing from you soon. If you have any questions, please feel free to contact Medical Volunteers Department at 1-888-OPSMILE (888-677-6453) or via e-mail at credentialing@operationsmile.org.

Best regards,

Medical Volunteers Department

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MEDICAL MISSION CHILD LIFE SPECIALIST VOLUNTEER APPLICATION

Name:_____ _____ _____
(Last) (First) (Middle)

Home Phone: (_____)_____ Work Phone:(_____)_____

Cell Phone: (_____)_____ Email:_____

Home Address:_____

City:_____ State:_____ Zip:_____ Country:_____

Place of Work: _____

Work Address: _____

City: _____ State: _____ Zip: _____ Country:_____

Preferred Mailing Address (check one): ____Home Address ____Work Address

CERTIFICATION:

Are you a Certified Child Life Specialist as per authorization of the Child Life Council (CLC)?

_____YES - Certification #: _____ Expiration Date: _____/_____/_____

_____ NO

Are you currently eligible for CCLS certification as per the requirements of the CLC? And if so are you scheduled to take the certification exam?

_____YES - Test Date: _____/_____/_____

_____NO

EXPERIENCE:

Please indicate time worked as a paid CCLS with the following age groups:

_____Infants _____Toddlers _____School Age _____Adolescents

Please indicate time worked as a paid CCLS in the following areas:

_____In-patient Medical / Surgical

_____In-patient Oncology

_____In-patient Neurosurgery

_____Out-patient Clinics (please list)

_____Emergency Department

_____Craniofacial

_____Pediatric ICU

_____Neonatal ICU

_____Other (explain): _____

CHILD LIFE INTERNSHIP EXPERIENCE:

Organization: _____ Dates: _____

Role / Responsibility: _____

Contact Name: _____ Phone: (_____) _____

RELATED EXPERIENCE:

Organization: _____ Dates: _____

Role / Responsibility: _____

Contact Name: _____ Phone: (_____) _____

Languages spoken and sign language (please indicate level of fluency):_____

_____

_____

Are you available on short notice to join a mission team?

- ❑ Yes with 1 – 2 weeks notice
- ❑ Yes with 3 – 4 weeks notice
- ❒ No

Short notice availability does not affect the application process but allows Operation Smile to adjust to the changing circumstances of our mission countries and volunteers.

PASSPORT INFORMATION

Passport #:_____ Passport Type:_____

Date of Birth:_____ Place of Birth:_____

Nationality:_____

Issuing Authority name and city:_____

Date Issued:_____ Expiration:_____

On a separate sheet, please explain how you learned about Operation Smile and why you want to participate on an Operation Smile Mission.

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References

Please provide information for three individuals from within your specialty who can attest to your clinical ability, professionalism, and ability to work as a part of a team in high-stress situations. **One of these references MUST be your current Supervisor**. Our Child Life Specialty Council may contact these references during the application review.

Reference #1

Name:_____
Position: _____
Company/Hospital: _____
Telephone #:_____
Email: _____
For how long did you work closely with this reference? _____ years _____ months
In what capacity did you work with this reference? _____
_____
Is this reference an Operation Smile volunteer? (circle) YES NO

Reference #2

Name:_____
Position: _____
Company/Hospital: _____
Telephone #:_____
Email: _____
For how long did you work closely with this reference? _____ years _____ months
In what capacity did you work with this reference? _____
_____
Is this reference an Operation Smile volunteer? (circle) YES NO

Reference #3

Name:_____
Position: _____
Company/Hospital: _____
Telephone #:_____
Email: _____
For how long did you work closely with this reference? _____ years _____ months
In what capacity did you work with this reference? _____
_____
Is this reference an Operation Smile volunteer? (circle) YES NO

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APPLICATION PROCESS:

Please send this completed application along with:

- **Current Curriculum Vitae/Resume**
- **Current copy of CCLS certification (if applicable)**
- **Copies of diplomas and degrees**

It is very important that you send all of the above information together with the completed application. If any of the above information is not in the application packet, the application is considered incomplete. You will be notified if your application is incomplete.

Completed application packets will be sent to their respective medical specialty council for review at which time you may be interviewed by telephone or asked to submit additional information. Operation Smile will inform you of the results of your application.

If an applicant is selected for a mission, all of his/her work will be done on a volunteer basis. Transportation and lodging are provided by Operation Smile, but each team member will be required to pay a sponsorship fee ($500) to help defray part of the mission expenses. Mission selection guidelines state that all mission teams are to be comprised of at least 50 percent experienced Operation Smile team members and the remainder of the team of new volunteers.

Please send all completed forms to:

Operation Smile
Medical Volunteer Management
6435 Tidewater Drive
Norfolk, VA 23509-1600
USA

I have read the above and certify that the foregoing is true, correct and complete. I shall promptly inform Operation Smile if there is any change to the facts herein.

Signature: _____ Date:_____