Operation Smile
Changing Lives One Smile at a Time

Dear Pediatrics Applicant:

Thank you for your interest in becoming an Operation Smile Pediatrics 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
- Copies of diplomas
- Current licensure
- Current Board certification
- Current PALS certification

PALS certification is required for Operation Smile Pediatrics volunteer approval.

Please do not send incomplete application packages. Upon receipt of your complete application packet, it will be forwarded to the Pediatrics Council for review. The Council Chair 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 Pediatrics 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 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 the 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 PEDIATRICIAN/PEDIATRIC INTENSIVIST VOLUNTEER APPLICATION

Select from the following Operation Smile accepted pediatric specialties only.
(Please note, pediatric intensivist is a fellowship-prepared, formally trained position.)

✓PLEASE CHECK ONE✓

____**Pediatrician** ____**Pediatric Intensivist**

____**Third Year Pediatric Critical Care Fellow** ____**Pediatric Emergency Medicine**

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

Please complete the following information:

Board Certification in pediatrics: ❑ YES Date:________________ ❑ NO

Board Certification in pediatric critical care: ❑ YES Date:________________ ❑ NO

Have your medical privileges ever been suspended? ❑ YES ❑ NO

If YES, please explain? ____

____

Do you still practice in your stated specialty? ❑ YES ❑ NO

6435 Tidewater Drive, Norfolk, VA 23509 (757) 321-7645 Phone (757) 321-7772 Fax
www.operationsmile.org

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PALS Certified: ❑ YES (Required)

NALS Certified? ❑ YES ❑ NO

ACLS Certified? ❑ YES ❑ NO

Instructor Certification: Operation Smile has initiated a program of taking ACLS and PALS courses to its mission countries. If you are a certified instructor for ACLS and/or PALS and would be interested in participating on one of the training missions, please check the appropriate box(es) and include a copy of your Instructor Certificate with your application. Instructor certification is not required to participate on surgical missions.

❑ ACLS Instructor ❒ PALS Instructor

Have you ever participated in any overseas medical/healthcare work? ❑ YES ❑ NO

If YES, please provide organization and contact phone number: ________________________________

____

____

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:______________________________

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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 the head of the department where you practice. Our Pediatrics 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 licensure**
- **Copies of medical diploma and related fellowships/residencies**
- **Current copy of Board certification**
- **Current copy of PALS certification**

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 complete 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:_______________________________