Operation Smile
Changing Lives One Smile at a Time

OPERATION SMILE MEDICAL MISSION- VOLUNTEER APPLICATION FOR SPEECH-LANGUAGE PATHOLOGISTS

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

Home Address:

Home Address (Street):_____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Home Phone: _____ Fax: _____

Cell Phone : _____

E-Mail: _____

Work Address:

Place of Employment: _____

Work Address (Street): _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Work Phone: _____ Fax: _____

E-Mail: _____

***Preferred Mailing Address (check one): ____ Home Address ____ Work Address

***NOTE: It is the clinician's responsibility to notify BOTH Operation Smile headquarters AND the Chairperson of Operation Smile's Speech Pathology Council of any *changes* in contact information.

Other Contact (Family/friend to contact if you have moved and we don't have info for changed phone/address or to send notification about mission/travel plan changes):

Name: _____

Relationship: _____

Phone: (_____)_____

E-mail: _____

Social Security # (or country identification #, if applicable): _____

Affiliation with an Operation Smile Chapter: ____ Yes (Specify: _____) ____ No

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

If YES, please comment: _____

_____

PASSPORT INFORMATION

Passport#:_____ Passport Type:_____

Date of Birth:_____ Place of Birth:_____

Nationality: _____

Issuing Authority name and city: _____

Date Issued:_____ Expiration:_____

Languages Spoken : Please indicate below the language/s you speak and your *level of fluency/proficiency* for each one in which you have at least some proficiency. *Examples of fluency levels:*

-Native speaker of the language/advanced fluency of a native speaker
-Advanced level of fluency (but not that of a native speaker of the language)
-Intermediate to advanced fluency
-Intermediate fluency
-Basic to intermediate fluency
-Basic fluency (comprehension and expression for a small core of words/ sentences)
-Social greetings/words only

Language/s	***Level of Proficiency***
_____	_____
_____	_____
_____	_____

NOTE: P*rior to going on a mission* the clinician is responsible for obtaining information about the phonemes and descriptions about the language and culture of the mission country. This information should be obtained both in *written form* (i.e., phoneme/language/cultural info in guidebooks) and in an *auditory-verbal format* (i.e., listening to tapes/videos or listening to native speakers of a language to gain an understanding of what the "normal" sound of the language is):

Education and Experience in Clefts/Craniofacial Anomalies and Related Speech-Language-Feeding Problems, Assessment, and Intervention:

Please read each statement and indicate your responses along with applicable comments.

- I have taken a specific university-level course in clefts/craniofacial anomalies and related speech, language, feeding problems (verified on my university transcript).

  _____ Yes _____ No

Comments: _____

_____

- If requested, I could verify that I regularly update my knowledge of clefts/ craniofacial disorders by way of lectures, seminars, workshops and other continuing education programs in this area.

  _____ Yes _____ No

Comments: _____

_____

- I am teaching or have taught a course or seminar on clefts/craniofacial anomalies.
  _____ Yes _____ No

Comments: _____

_____

- If requested at a mission site, I could give presentations on the role of the speech pathologist on an interdisciplinary cleft/craniofacial team with individuals at different ages/ developmental levels, a review of the speech, language, and feeding issues that can occur with clefts/craniofacial anomalies, any aspect of velopharyngeal functioning/ dysfunction, uses and problems with palatal prostheses, and other related topics.
  _____ Yes _____ No

Comments: _____

_____

- I currently am a member (or have been a member) of a cleft/craniofacial team.
  _____ Yes _____ No

Comments: _____

_____

- I currently am a member of the American Cleft Palate-Craniofacial Association.
  _____ Yes _____ No
- I currently am a member of the American Speech-Language-Hearing Association's Special Interest Division on Speech Science and Orofacial Disorders.
  _____ Yes _____ No
- I currently am a member of a Cleft/Craniofacial Association or special interest group for clefts/craniofacial disorders in another country (outside of the USA).
  _____ Yes _____ No

If "Yes," please specify: _____

- I currently seeing cleft lip and palate patients.
  _____ Yes _____ No

If so how many: _____

- I see these cleft lip and palate patients.
  _____ daily _____ weekly _____ monthly
- I see these cleft patients for:
  _____ therapy _____ evaluation _____ both
- I am proficient in VPI diagnostic procedures:
  _____ Yes _____ No
- I see cleft patients primarily in which of the following settings:
  _____ hospital _____ school _____ private clinic _____ other_____

- I regularly have individuals on my caseload who have *speech* problems related to clefts/craniofacial anomalies.
  _____ Yes _____ No

Please specify and comment on the number of recent CEUs and how you obtained those CEUs with specific reference to *speech* problems related to clefts/craniofacial anomalies:

_____
_____

- Please indicate other areas of expertise in the field of speech-language pathology:

_____
_____

- Please indicate population of patients/clients along with approximate caseload percentages that you have had experience with in the last 3-5 years:

	Patient Polulation	Caseload Percentage		
_____	Infants/Toddlers (Birth to 3 years old)	Approximate	_____	%
_____	Preschool (3 to 6 years old)	Approximate	_____	%
_____	Elementary School/Middle School Children	Approximate	_____	%
_____	Adolescents/High School Youth	Approximate	_____	%
_____	Adults (Young to Middle-Aged Adults)	Approximate	_____	%
_____	Adults (Older Adults/Seniors)	Approximate	_____	%

Mission Assignments and Preparation:

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.

Please read the following statements and put a check in the space provided below to acknowledge your understanding.

- The speech pathologist (or a designee) *must* notify the Mission Coordinator *and* the Chairperson of the Speech Pathology Council *immediately* (to the extent possible) if he/she cannot go on a mission to which an assignment has been accepted. Cancellation less than one to two months prior to a mission could make it very difficult to obtain a substitute and should be done only if absolutely necessary.
- It is the speech pathologist's responsibility to keep abreast of changes in mission dates.
- The speech pathologist is responsible for adhering to the job description/guidelines for speech pathologists going on missions and contacting others who have been to a mission site before.
- Prior to a mission, the speech pathologist is responsible for obtaining or developing a speech-language screening tool for the country to which she/he is assigned (NOTE: provided on request if already available) and becoming informed about the speech and language of the host country/mission site.
- The speech pathologist is responsible for obtaining (via donations* or paying personally) the supplies and equipment needed by the speech pathologist on the mission. *[*Donations: Check with Speech Pathology Council Chair or designee to determine who can be asked to make donations.)*

(Put check mark here) _____ I have read and understand the information above.

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APPLICATION PROCESS

Please send this completed application to the Operation Smile Credentialing Coordinator along with *all* of the following:

- **An up-to-date Curriculum Vitae/Resume**
- **Copy of current state licensure (if applicable to your state/province)**
- **Copy of current ASHA Certification (CCC) (or equivalent from other country)**
- **Copies of Diplomas/University Degrees**
- **Three (3) References from professionals who know of your work as a speech pathologist** (preferably all three recommendations will be from speech pathologists, but references from physicians who know of your work or from supervisors/ administrators who are not speech pathologists can also be used: a minimum of one recommendation should be from a speech pathologist)

Please remember that this is a professional-level application. Letters of recommendation should be typed on letterhead with contact information for the author.

It is very important that you send all of the above information *together* with the completed application. Please do not have letters of recommendation sent directly to the Credentialing Coordinator rather than with your 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 applications will be sent to the Chairperson of the Speech Pathology Council for review and final approval. After the coordinator receives the application, you may be interviewed by telephone or asked to submit additional information. **Please allow 6-8 weeks for application processing.** The Credentialing Coordinator will notify you on the results of your application.

PLEASE NOTE: If an applicant is selected for a mission, all of his/her work will be done on a *volunteer* basis. Operation Smile provides transportation to and from the mission site, lodging, and some meals, but each team member is required to pay a sponsorship fee ($500 subject to increase as determined by Operation Smile) to help defray part of the mission expenses. The volunteer must also pay for any applicable airport departure taxes/fees, personal phone and laundry charges, and some other individual expenses. In addition volunteers have a responsibility to obtain any recommended immunizations or personal medications that he/she might need on the mission. Furthermore, speech pathologists will need to provide equipment, supplies, and related items as indicated above. (Note that other team members in certain specialties will also need to bring certain equipment/supplies.)

Mission teams are comprised of at least 50 percent experienced Operation Smile team members and the remainder of the team of new volunteers. A higher percentage of experienced volunteers might be required at some mission sites.

Please send all forms, required documents to:

Operation Smile
Medical Volunteer Department
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: _____

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