Operation Smile

Changing Lives One Smile at a Time

Dear Plastic Surgery Applicant:

Thank you for your interest in becoming an Operation Smile Plastic Surgery 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 licensure
- Current Board 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 Plastic and Reconstructive Surgery Council for review. The Plastic and Reconstructive Surgery Council may telephone you to clarify information and determines the recommendation status of the application. This process can take up to 8 weeks.

Operation Smile will inform you of the results of your application. Upon approval by the Plastic and Reconstructive Surgery 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 VOLUNTEER SURGEON 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

## PLEASE CHECK APPROPRIATE SPECIALTIES

Please select from the following specialties ONLY. Check more than one if applicable.

**____Plastic Surgeon** **____Micro Surgeon** **____Burn Surgeon**

Please answer the following questions honestly. The well being of patients rely on your credibility and expertise. If you do not have enough experience in these specific areas particularly working with cleft lips and palates on pediatric patients, you may re-apply at a later time. **Your application will be considered incomplete if any question is left unanswered.**

1. How many cleft lips have you done in the past year? _____

   a) How many cleft lips have you done in the past 5 years? _____

   _____

   b) How many cleft lips have you done in your surgical career? _____

   _____

   Explain. _____

   _____

2. How many cleft palates have you done in the past year? _____

   a) How many cleft palates have you done in the past 5 years? _____

   _____

   b) How many cleft palates have you done in you surgical career? _____

   _____

   Explain. _____

3. Would you be comfortable performing surgery at your own table (with little or no supervision) with good to excellent surgical results? Explain._____

   _____

   _____

4. Do you have any experience working on medical missions? _____

   _____

5. How long does it take for you to perform your standard cleft lip operation? _____

   _____

6. How long does it take you to perform your standard cleft palate operation? _____

   _____

7. What is your experience with burn reconstruction (be specific)? _____

   _____

   a) How many reconstructive burn cases have you performed in the past year? _____

   _____

   b) How many reconstructive burn cases have you performed in the past five years? _____

   _____

8. What is your experience with hand surgery (be specific)? _____

   _____

   a) How many hand surgery cases have you performed in the past year? _____

   _____

   b) How many hand surgery cases have you performed in the past five years? _____

   _____

9. Are you experienced and comfortable performing Pharyngoplasties?_____

   _____

**CURRENT EXPERIENCE:** Please indicate which types of patients/programs you have had experience with in the last 3-5 years, and describe your current work.

____Pediatrics (0-6 years old)
____Youth (7-14 years old)
____Adult (over 14 years old)
____Burn reconstruction
____Orthopedics
____Craniofacial

Please briefly describe the nature of your current work:

_____
_____

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Are you affiliated with a:

❑ Cleft Center – Name:_____

❑ Burn Center – Name:_____

In what capacity? _____

Specialty Training:

| | School / Hospital | Dates | Degree(s) |
|---|---|---|---|
| Cleft Lip | | to | |
| Cleft Palate | | to | |
| Burns | | to | |
| Flaps | | to | |
| Hand Surgery | | to | |
| Microsurgery | | to | |
| Club Foot | | to | |
| Pediatric Ortho | | to | |
| Peds Anesthesia | | to | |
| Other | | to | |

Board Certified: ❑ YES Specialty:_____ Date:_____ ❑ NO

Board Eligible: ❑ YES Specialty:_____ Date:_____ ❑ NO

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

If YES, please explain:_____

_____

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

If YES, explain:_____

_____

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 Plastic Surgery 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

## *APPLICATION PROCESS:*

Please send this completed application along with:

- **Current Curriculum Vitae/Resume**
- **Current copies of licensure**
- **Current copy of Board 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:_____**