



ALOHA MEDICAL MISSION

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New Volunteer Application – Physicians, Surgeons & Dentists

Please print clearly. Use black or dark blue ink only.

Place of mission interested: _____ Dates of mission: _____

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PERSONAL	Full Name: _____ Gender: _____ Date of Birth: _____
	Mailing Address: _____
	Business Address: _____
	Home Phone: _____ Business Phone: _____
	Cellular Phone: _____ Fax: _____
	E-mail: _____
	Emergency Contact: _____ Relationship: _____
Address: _____	
Primary Phone: _____ E-mail: _____	

Primary Phone:
 Home
 Business
 Cellular

EDUCATION	Prof. School Graduated: _____ Degree Awarded: _____ Year: _____
	Graduates of Foreign Medical Schools: ECFMG #: _____
	Place of Residency: _____
	Type: _____ Dates Served: _____
	Place of Fellowship: _____
	Type: _____ Dates Served: _____

PROFESSIONAL	Specialty: _____ Board Certified? Y N Year: _____
	Specialty: _____ Board Certified? Y N Year: _____
	Status: <input type="checkbox"/> Retired – Year: _____
	<input type="checkbox"/> Active – Private Practice? Y N Employed By: _____
	Liability insurance carrier: _____ Exp. Date: ____/____
Have you had any regulatory actions taken against you that limited your medical practice in any way? Y N If yes, please describe on separate page.	

LICENSES	List all current licenses. A copy of each license must be attached.
	State/Country: _____ Medical License #: _____ Exp. Date: ____/____
	State/Country: _____ Medical License #: _____ Exp. Date: ____/____

OTHER

Foreign language(s) and proficiency level: _____

Have you been on a mission with another organization? Y N If yes, where? _____

When? _____ What organization? _____

What types of cases were seen/performed on this mission

Please describe your skills and interests relevant to the missions you are applying for:

How did you hear about Aloha Medical Mission? _____

Have you spoken to an AMM member/mission leader regarding your application? Y N

If yes, who? _____

Please list professional and personal references.

Name: _____ Relationship: _____

Phone: _____ E-mail: _____

Name: _____ Relationship: _____

Phone: _____ E-mail: _____

Name: _____ Relationship: _____

Phone: _____ E-mail: _____

By signing below, I attest that all of the information provided in this application (and accompanying documentation) is true and complete to the best of my knowledge.

Signature: _____ Date: _____

Along with this application, please submit your résumé and a copy of each of your current licenses.