ALOHA MEDICAL MISSION

810 N. Vineyard Blvd.
Honolulu, HI 96817-3590 U.S.A.
(808) 847-3400 • Fax: (808) 847-3443
E-mail: info@alohamedicalmission.org
Website: www.alohamedicalmission.org

New Volunteer Application – Nurse

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

Place of mission interested: ________________________ Dates of mission: ________________

Place of mission interested: ________________________ Dates of mission: ________________

PERSONAL

Full Name: ______________________________ Gender: M F Date of Birth: ____________

Mailing Address: ____

Business Address: ____

Home Phone: ________________ Business Phone: ________________

Cellular Phone: ________________ Fax: ________________

E-mail: ____

Primary Phone:
- ☐ Home
- ☐ Business
- ☐ Cellular

Emergency Contact: ______________________ Relationship: ______________________

Address: ____

Primary Phone: ________________ E-mail: ______________________________

EDUCATION / PROFESSIONAL

Nursing School Graduated: ______________________ Degree Awarded: ________ Year: ______

Specialty(ies): 1. ______________________________

2. ______________________________

Status: ☐ Retired – Year? ________

☐ Active – Private Practice? Y N Employed By: ______________________________

Liability insurance carrier: ______________________ Exp. Date: _____/_____

Have you had any regulatory actions taken against you that limited your nursing practice in any way? Y N
If yes, please describe on separate page.

LICENSES

List all current licenses.

State/Country: ________________ Medical License #: ______________ Exp. Date: _____/_____

State/Country: ________________ Medical License #: ______________ Exp. Date: _____/_____

Nurse anesthetists only:

Exp. Date of CCNA certification: _____/_____ AANA ID #: ______________

REV032511

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? ______

REFERENCES

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.

REV032511