



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 – Physicians, Surgeons & Dentists

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

Place of mission interested: _____ Dates of mission: _____

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: _____	Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Cellular
	Cellular Phone: _____ Fax: _____	
	E-mail: _____	
	Emergency Contact: _____ Relationship: _____	
Address: _____		
Primary Phone: _____ E-mail: _____		

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? _____	

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.