# Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

### Home Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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

### Dental School Affiliation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PLEASE CHECK APPROPRIATE PROFESSIONAL DISCIPLINE

|  |  |  |
| --- | --- | --- |
| * Pediatric Dentist * Prosthodontist * Orthodontist * Endodontist | * General Dentist * Periodontist * Oral Maxiofacial Surgeon | * Other: (please specify)   ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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) \_\_\_\_Root Canal Therapy

\_\_\_\_Youth (7-14 years old) \_\_\_\_Periodontal Therapy

\_\_\_\_Adult (over 14 years old) \_\_\_\_Prosthetic Treatment

Please describe your experience with extractions, endodontics, restorations (amalgam and composite), and other procedures you do on a routine basis. In addition, please describe how comfortable you are working in pediatric dentistry.

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##### Board Certified: ❑ YES Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ ❑ NO

Board Eligible: ❑ YES Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ ❑ NO

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

If YES, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If YES, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Foreign languages and sign language (please indicate level of fluency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 Hope For Tomorrow 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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.Hope For Tomorrow 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. In country transportation, lodging and meals are provided by Hope For Tomorrow, but each team member will be required to pay a sponsorship fee ($500) to help defray part of the mission expenses.

**Please send all forms to:**

###### HOPE FOR TOMORROW

**Attn: Mission Coordinator**

6811 Needwood Road

**Rockville, MD 20855**

**I have read the above and certify that the foregoing is true, correct and complete. I shall promptly inform Hope For Tomorrow if there is any change to the facts herein.**

### **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For OFFICE use ONLY:

### Received (date): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_ Capture #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Payment Form

**Please charge the $500.00 sponsorship fee to my (check one):**

**❑ MasterCard ❑ American Express**

**❑ VISA ❑ Discover**

**Name:** (**as it appears on your credit card**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration Date (mm/yy):** \_\_\_\_\_/\_\_\_\_\_

**Signature (*required* for CREDIT CARDS):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_