



7449 Burbank St.
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Medical Volunteer Application

(Please type or print clearly. Use black or dark blue ink only.)

Name: _____ Gender: M F DOB: _____

Mailing Address: _____

Business Address: _____

Home Phone: _____ Business Phone: _____ Fax: _____

Cell Phone: _____ E-mail: _____ Best time/number to Call _____

Marital Status: S M Spouse name (if applicable): _____

School Graduated: _____ Degree Attained: _____ Year: _____

State (s) or Country (ies) in which you are licensed to practice: _____

Specialty (ies): _____ Subspecialty: _____

Internship: _____ Year: _____ Residency: _____ Year: _____

Specialty Board Eligible? Y N Certified?: Y N Recertified? Y N Year: _____

Are you in private practice? Y N If yes, where? _____ How long? _____

Retired?: Y N Other positions held, if not in private practice: _____

Hospital Affiliations (s): _____

Professional awards, honors or recognitions received or other special attainments:

What organizations do you belong to?: _____

Have you been on other missions? Y N Where: _____ When: _____

Current medical license? Y N State(s) _____ Has your license been suspended in the past 5 YRS? Y N

Medical license #: _____ Expiration Date: _____

Emergency Contact Information Name: _____

Phone: _____ Relationship _____

Mission interested in: _____ Date of mission: _____

Signature: _____ Date: _____

*Please enclose copies of 1) Current medical license; 2) diploma from medical school
3) Post graduate training certificate; 4) Specialty board certificates; 5) current CV*

Please fax or mail to WE Serv Mission for the Poor