Office Use Only
TB___ DB___QBS___EML___ TMDB___SSDB___

Name:_____
Specialty:_____

PO Box 273, Palm City, FL 34991
Phone (772) 223-9781
Fax (772) 223-9783
www.lightoftheworldcharities.com

VOLUNTEER APPLICATION

I am a MEDICAL PROFESSIONAL _____YES _____NO
I am interested in volunteering for (Please Check all that apply):

- ☐ Missions Abroad
- ☐ USA Dental Program (Palm City, FL.)
- ☐ USA Stateside Surgery Program (Palm City, FL.)
- ☐ Central Supply (Palm City, FL)
- ☐ Banquet & Luncheon Planning
- ☐ Palm City Office Volunteer

(Please Print Clearly)

Date: _____

Name: _____
Last First Middle

Address:_____
Street City State Zip Code

Phone: _____
Home Business Cell

Date of Birth: _____ Citizenship_____ E-mail: _____

PROFESSIONAL TITLE: _____ AREA OF SPECIALTY _____

ALL Volunteer Applicants (Medical and NON-Medical) please submit a current resume (if you already have one), listing your work experience, educational background, etc. ***If interested in the Missions Abroad Program*** *please mail or e-mail a colored copy of your passport to the address above* (do not attempt to fax a passport).

All Medical Professionals must submit a legible copy of **current medical license** with expiration date clearly marked, certifications and diplomas.

All Physicians must also submit diplomas from medical school and school of surgical specialty, along with their current curriculum vitae (CV).

Please feel free to scan and email documentation to info@lowtc.us. Please do not attempt to fax passports.

REFERENCES: (Professional and Character):

1. Name: _____
   Phone, Address and Title: _____
   _____
2. Name: _____
   Phone, Address and Title: _____
   _____
3. Name: _____
   Phone, Address and Title: _____
   _____

Are you Fluent in any other languages?

_____

Previous Community Service: _____

_____

Previous overseas volunteer experience: _____

_____

Previous Travel Experience: _____

_____

Religious Affiliation: _____

MEDICAL HISTORY:

Heart or Lung Problems (Asthma):_____

Diabetes: _____

High Blood Pressure: _____

Allergies: _____

Other: _____

Medications: _____

In Case of Emergency please notify: _____

Relationship _____ Phone #_____

***Please let us know the name of the person that referred you to Light of the World Charities or how you heard about us:**

_____

Why do you want to volunteer with LOTWC? _____

_____

_____

_____

Are you willing to accept the responsibility to assist in preparing for the Programs/Missions/Projects PRIOR to the departure or scheduled date? When are you available to assist?

_____

_____

I am willing to travel to the following countries:

☐ Africa (*Team Member pays for 100% of airfare*) Haiti ☐ Honduras ☐ Nicaragua ☐ Ecuador ☐

I am able to participate on more than one mission trip per year. YES ☐ O ☐

MEDICAL VOLUNTEERS ONLY:

I have worked in the OR for _____years
I have scrubbed for _____years.
I have circulated for _____years.
I have worked Recovery Room or ICU for _____years.
I am CNOR certified Yes_____ NO_____.
I have other certifications which include: _____
I have worked in the area of my specialty, which is _____ for _____ years.

I hereby affirm that the above information is accurate and complete

Signature _____Date_____

Questions/Comments:_____

_____

_____

Path: Public/Application Forms/Revised 2013 Applicaiton