Cambodian Health Professionals Association of America
សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

CHPAA Mission 9 Application

(February 6th – February 21st, 2019)

Every Question Must Be Completed and All Attachments Must Be Sent by 11/10/18

Last Name (as in passport):_____First Name:_____Title:_____

(If Passport expires less than 6 months from date of return, you will be unable to travel.)

Passport No:_____Date of Issue:_____Exp. Date:_____

Citizenship:_____DOB:_____Gender: M_____F_____

Address: Home:_____City/State/Zip_____

Work:_____City/State/Zip_____

Phone: Home:_____Cell:_____

Work:_____Cell:_____

Email:_____

Emergency Contact(s) Name:_____Relationship:_____

Phone Number: _____Work:_____

Address:_____City/State/Zip_____

Required For Health Professionals:

(In the US only) License No:_____State:_____Exp. Date:_____

Specialty:_____Board Certification(circle): No/Yes Recertification Year_____

(Outside of the US only) License:_____Country:_____

Place of Employment:_____Position:_____

Have you ever been to other Medical Missions?

No____Yes___When_____Where_____

Foreign Languages Spoken and Proficiency:_____

What best describes your health:_____

Fair (Please explain):_____

Are you currently taking any medication? Yes ☐ No ☐

Cambodian Health Professionals Association of America
សមាគមសុខាតិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

List:_____

How did you hear about this CHPAA Mission:_____

Describe your personal strengths and weaknesses:_____

_____

Immunization Status: _____ Up-to-date for Cambodia (Please consult your physician)

Scrub Size (Circle): S M L XL XXL NONE (I have from previous year)

Please kindly use last year's scrubs to defer funds for CHPAA's special projects.

If my application is approved, I agree to abide by CHPAA Code of Conduct: Yes_____No_____

_____ _____ _____

Signature Print Name Date

Please send the following: **(Make Sure to Send a Complete Package through Mail or Email to CHPAAMISSION8@yahoo.com)**

1. Signed Application Form
2. Curriculum Vitae (Required by the Ministry of Health in Cambodia)
3. Copy of License (for Health Professionals) and DEA (for Physicians)
4. Signed Memorandum of Understanding Form
5. Signed Waiver and Release of Liability Form
6. Signed Code of Conduct Form
7. Signed Media and Publicity Release Form
8. Copy of Passport (Valid 6 months from the date of travel)
9. A Headshot photo for ID Badge (Hard Copy or by Email)
10. Copy of flight information (Itinerary ASAP)

11. A check payable to CHPAA Mission
    Send check to: "CHPAA"
    930 Pine Ave. Long Beach, CA, 90813

- **Mission & Tour (2/6/19 – 2/21/19)**
  ☐ Package A1: $ 1200 **(Single Occupancy)**
  ☐ Package A2: $ 1050 **(Double Occupancy)**

- **Mission Only (2/6/19 – 2/18/19)**
  ☐ Package B1: $800 **(Single Occupancy)**
  ☐ Package B2: $700 **(Double Occupancy)**

**** AIRFARE IS SEPARATE & RECOMMENDATIONS WILL BE MADE AS NEEDED**

☐ Have you mutually agreed-upon a roommate?
Name_____
☐ Please place me with a roommate. I understand that this may not be possible.
I am prepared to pay SINGLE occupancy if no match. _____Initials

Cambodian Health Professionals Association of America
សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

MEMORANDUM OF UNDERSTANDING

I hereby volunteer my services for the treatment of indigent people in Cambodia during the period of

February 6, 2019 - February 21, 2019.

I understand that the Cambodian Health Professionals Association of America (CHPAA) serves as the organization for this act of charity and humanitarian concern. CHPAA is responsible for much of the administration and logistic work.

I understand that I will pay my own round-trip airfare expenses between _____ (your state) and Cambodia.

I understand that no volunteer, including the medical director or others are paid for any services rendered to the patients, and that no one involved with CHPAA receives any remuneration for work performed about the charitable mission.

I understand that I may keep copies of medical records for any of the patients I treat and that I may keep data, including photographs, for any of the cases I handle. I understand that I will have to bring some medical and surgical instruments, and any other equipment and supplies I may need to render medical services to patients in Cambodia. (Pertains to medical professionals only)

I understand that I am obligated to adhere to the Cambodian Health Professionals Association of America, CHPAA's Volunteer Code of Conduct, attached to this Memorandum, and to abide by it during my participation in this mission.

I further understand that my work with the Mission shall not in any way be used for advertising, marketing or any other commercial purpose without prior approval and written consent of the Board of Directors of CHPAA.

_____ _____

Name (Please PRINT) Signature

_____

Date

Cambodian Health Professionals Association of America
សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

WAIVER AND RELEASE OF LIABILITY

I hereby release the Cambodian Health Professionals Association of America (CHPAA), its officers, and Board of Directors from all liability for any acts or omissions related to the rendering of medical services to the patients in Cambodia, in connection with the medical mission leaving the U.S.A. on the February 6th, 2019 and returning on the February 18th or February 21st, 2019.

I fully understand that the mission has risks of accident, injury or disease, which may be caused by my own actions or inactions, the actions or inactions of CHPAA or others, or the conditions at the locations where the mission will take place. There may be other potential risks either not known to me or not readily foreseeable now. I fully accept and assume all such risks and all responsibility for losses or damages I may incur due to my participation in the mission. I certify that I am qualified, in good health and in proper physical condition to participate in the mission.

I further hereby waive and release all rights and claims for loss or damage, at law or in equity, that I may have against CHPAA, its officers, volunteers and Board of Directors now or in the future for all illness, injury, loss or damage suffered by me as a result of my participation in this mission, even if the loss or damage is caused by the person I am releasing. This Waiver and Release is binding on my heirs, successors, assigns, personal representatives, administrators and executors.

I certify that I have read the contents of this document, fully understand its provisions, and freely execute this Waiver and Release.

DATED in _____(current location), this _____day of_____(Month), 20____(Year)

Name (printed):_____Signature:_____

Cambodian Health Professionals Association of America
សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

VOLUNTEER CODE OF CONDUCT

1. Support the vision of the CHPAA.
2. Uphold the highest personal and professional conduct in mission assignment, treat patients and families with dignity and compassion, display mutual respect to fellow volunteers.
3. Be sensitive to local beliefs, respectful of local traditions, culture and religions.
4. Work collaboratively with local health professionals, encourage exchange of ideas and knowledge, treat our hosts with courtesy and respect at all times.
5. Make no judgment or criticism of the local facilities or their way of doing things.
6. Refrain from making political statements and criticism of the host government and its officials, from participating in any activity or making any remarks that reflect negatively on this CHPAA mission.
7. Do not promise any CHPAA supplies, equipment or medications to a particular patient, health facility, group or individual. Also, refrain from taking supplies, equipment or medications at the conclusion of the mission.
8. Conserve supplies and medications. These are donated or purchased with donated funds. They are expensive and sometimes impossible to replace locally.
9. If unable to fulfill your assignment for any reason and need to be absent, please inform and discuss promptly with mission leaders.
10. If you know you will have a late arrival or early departure from the mission, we MUST know one month in advance in order to cover all volunteer positions at all times.
11. Pay attention to your own health needs and personal safety at all times. Please do not engage in any activities that can jeopardize your health or safety.
12. Be flexible during the mission. Remember that the mission was organized 100 percent by volunteers. When things go wrong, try to help.
13. The CHPAA designated uniform and ID badge must be worn at all times during the mission work.

I fully agree to abide by the CHPAA code of conduct outlines above and signed in the application form.

_____ _____

Signature Date

Cambodian Health Professionals Association of America
សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក
930 Pine Avenue, Long Beach, CA 90813 Phone: (562) 269-5658 Fax: (562) 495-1878 www.chpaa.org
Email: chpaamission9@yahoo.com

MEDIA AND PUBLICITY RELEASE FORM

I _____ give the Cambodian Health Professionals Association of America (CHPAA), and other agents acting on behalf of CHPAA, including any photographer or videographer, permission to use my name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of CHPAA program activities. I agree that CHPAA have complete ownership of such pictures, including the entire copyright, and may use them for any purpose consistent with CHPAA's mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensations, etc. for the use of such pictures, etc., and hereby release CHPAA and their agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to CHPAA to use my name likeness to promote CHPAA's programs, its affiliated partners, and/or their activities.

_____ _____

Signature Date

_____ _____

Parent/Legal Guardian (if age 17) Date

I do not give my consent to CHPAA to use my name and likeness to Promote CHPAA's programs, its affiliated partners, and/or their activities.

_____ _____

Signature Date

_____ _____

Parent/Legal guardian (if age 17) Date