

# Cambodian Health Professionals Association of America

## សហគមន៍សុខាភិបាលខ្មែរនៅអាមេរិក

1025 Atlantic Ave, Long Beach, CA 90813, USA Phone: 562-491-9292 Fax: 562-495-1878 www.chpaa.org

### CHPAA MSDM Mission 7 Application ( February 8, 2017 - February 23, 2017)

Name (as in passport): Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Title \_\_\_\_\_

Passport No: \_\_\_\_\_ Date of Issue: \_\_\_\_\_ Date of Exp. \_\_\_\_\_ Country of Birth \_\_\_\_\_

Citizenship: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Marital Status: Married \_\_\_ Single \_\_\_

Address: Home: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Work: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

#### For Health Professionals:

(In the US only) License No: \_\_\_\_\_ State: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Specialty: \_\_\_\_\_ Board Certification: No \_\_\_ Yes \_\_\_ Year \_\_\_\_\_ Recertification Year: \_\_\_\_\_

(Outside of the US only) License: \_\_\_\_\_ Country: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_ Duration: \_\_\_\_\_

Emergency Contact(s): Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_

Address: Street: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Have you been to other Medical Mission?

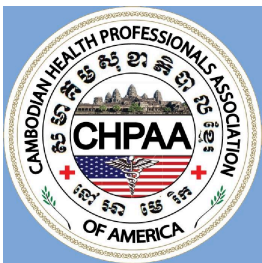
No \_\_\_ Yes \_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

Foreign Languages spoken and proficiency: \_\_\_\_\_

Special skills and areas of interest: \_\_\_\_\_

What best describes your Health?: Good \_\_\_ Fair \_\_\_ (please explain): \_\_\_\_\_

\_\_\_\_\_



# Cambodian Health Professionals Association of America

## សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក

1025 Atlantic Ave. Long Beach, CA 90813, USA Phone: 562-491-9292 Fax: 562-495-1878 www.chpaa.org

Are you currently taking any medications: No \_\_\_ Yes \_\_\_ (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)

If my application is approved, I agree to abide by CHPAA Code of Conduct: Yes \_\_\_ No \_\_\_

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

*Please send the following :*

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. 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
10. Copy of flight information (As Soon As Possible)

11. A check payable to CHPAA Mission. Send to:

1025 Atlantic Ave. Long Beach, CA 90813

- Mission & Tour (02/08/17 – 02/23/17)

- Package A1: \$ 1150 (single occupancy)
- Package A2: \$ 1000 (double occupancy)

- Mission (Only) (02/08/17 – 02/20/17)

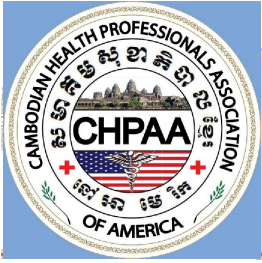
- Package B1: \$ 800 (single occupancy)
- Package B2: \$ 700 (double occupancy)

**\*\*AIRFARE IS SEPARATE & RECOMMENDATIONS WILL BE MADE FOR YOU**

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. \_\_\_\_\_ Initial



# Cambodian Health Professionals Association of America

## សមាគមសុខាភិបាលខ្មែរនៅអាមេរិក

1025 Atlantic Ave, Long Beach, CA 90813, USA Phone: 562-491-9292 Fax: 562-495-1878 www.chpaa.org

### MEMORANDUM OF UNDERSTANDING

I hereby volunteer my services for the treatment of indigent people in Cambodia during the period of February 8, 2017 – February 23, 2017.

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 the majority of the administration and logistic work.

I understand that I will pay my own round-trip airfare expenses between \_\_\_\_\_ (your state) and Cambodia, as well as lodging and any in-country expenses.

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 in connection with 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)

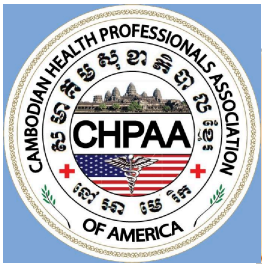
I understand that I am obligated to adhere to the Cambodian Health Professionals Association of America, CHPAA's Volunteer Code of Conduct, attached to this Memorandum, and to abide by it during my participation in this mission.

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 express written consent of the Board of Directors of CHPAA.

\_\_\_\_\_  
Name (Please PRINT)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**WAIVER AND RELEASE OF LIABILITY**

I hereby release the Cambodian Health Professionals Association of America (CHPAA), its officers, and Board of Directors from any and 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 8<sup>th</sup> of February, 2017 and returning on the 23<sup>rd</sup> of February, 2017.

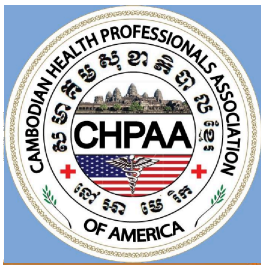
I fully understand that the mission has risks of accident, injury or disease, which may be caused by my own actions or inactions, the actions or inactions of CHPAA or others, or the conditions at the locations where the mission will take place. There may be other potential risks either not known to me or not readily foreseeable at this time. 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 any and 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 any and 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 \_\_\_\_\_ 20\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_



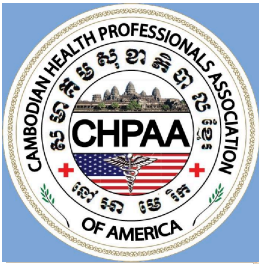
## **Volunteer Code of Conduct**

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. 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.
11. Be flexible during the mission. Remember that the mission was organized 100 percent by volunteers. When things go wrong, try to help.
12. 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 outlined above and signed in***

***application form:***

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Cambodian Health Professionals Association of America

## សហគមន៍សុខាភិបាលខ្មែរនៅអាមេរិក

1025 Atlante Ave. Long Beach, CA 90813, USA Phone: 562-491-9292 Fax: 562-495-1878 www.chpaa.org

### 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