

Email: _____

Dear Potential FOCOS Volunteer:

We appreciate your interest in volunteering in our Ghana West Africa Program

Important Information

- Applicants must be at least 18 years old at time of service and in good health.
- All volunteers are required to pay for their own transportation and will be responsible to provide proof of basic health insurance coverage. If you do not have sufficient coverage, a basic plan can be purchased through Medjet insurance their website is www.medjet.com.
- Volunteers should have orthopedic experience.
- HealthCare volunteers can apply for minimum of two weeks up to one year; however most positions are in the Operating Room.
- Once we receive your completed applications, the FOCOS Medical Advisory Committee will review it, the housing availability, and your qualifications. If accepted, a packet which has important trip information and outlines the details of your position, costs, and immunizations required, along with travel information, etc. will be sent.
- **PLEASE MAKE TRAVEL ARRANGEMENTS ONLY IF YOU HAVE RECEIVED AN ACCEPTANCE PACKAGE AND CONFIRMED DATES OF SERVICE.**

Completing and Submitting your Application:

- All forms should be completed in black ink or type-written. Use clearly printed English.
- Please send in the following, with your completed application:
 - A current resume or CV with date and signature
 - Copy of current licenses, certificates and certified professional diplomas.
- A current physical evaluation (completed within the last 12 months) maybe acceptable if there has been **no change** in your health history since the evaluation was completed and the form provides enough information to establish a thorough medical review.
- Three references are required prior to acceptance. However, if you are retired, unemployed, or do not have a pastor, please return the reference form blank with a note of explanation.
- Application and placement processing is done once the entire application, health forms, and references have been received and reviewed by our MAC.
- Please make a photocopy of your reference and return entire application to:

FOCOS
P.O. Box 665
Lenox Hill Station
New York, NY 10021

PHOTOS must be actual passport size. No other photos will be accepted. (ie. no digital photos, 4x6 photos, etc.)

For more information, please refer to www.orthofocos.org contact us by email or call us at 212 774-2663.

Thanks again for your interest in service with FOCOS. We look forward to having you as part of our team!

Oheneba Boachie-Adjei
Founder and President

Bettye Wright, P.A., R.N.
Chairperson Medical Advisory Comm.

Short-term HealthCare Volunteer Application

EMAIL _____

Name: _____

Complete Address: Street _____

City _____

Zip/Postal Code _____

Email _____

Phone Numbers: Home: _____ Work _____

Fax _____ Cell/Alternate _____

Date of Birth _____ Gender: Male _____ Female _____

Marital Status Married ___ Single ___ Separated ___ Divorced ___ Widowed ___

If married is your spouse applying? Yes ___ No ___ Spouse's Name _____

Length of time available: 1 week ___ 2 weeks ___ 4 weeks ___ Other _____

Dates available: From: _____ To: _____

Position Applying for: _____

Please attach your current curriculum vitae and copies of your current licenses, certificates and certified diploma to this form. Please note, license must be current and active to serve.

Please answer the following questions:

Y ___ N ___ Have you ever applied for and/or serviced with FOCOS in the past? If Yes when? _____

Y ___ N ___ Do you have any relatives/friends who have served with FOCOS? If Yes who? _____

Y ___ N ___ Are you able to raise the financial support necessary to serve with FOCOS ?

Y ___ N ___ Have you ever been named in a medical malpractice suit? If yes please explain:

Y ___ N ___ Have you ever been convicted of a criminal offense? If yes, please explain:

Y ___ N ___ Are there any circumstances (medical or other) which could interfere with your meeting the requirement of the position for which you are applying? If yes please explain:

Personal Profile:

Religion/Faith: _____

Please explain why you wish to serve with FOCOS: (If you need more space please attach a separate page).

Authorization:

While this application may be submitted to FOCOS – New York Office it will be reviewed and processed by the Medical Advisory Committee. I request that this application for service, and any additional information requested be forwarded FOCOS-Ghana. I hereby consent and authorize an investigation of my past and/present employment or credit check relative to any matters contained in my application and any matters relevant to consideration of my service. I hereby waive any and all notice of disclosures required by my past and present employer(s).

In consideration of possible service by FOCOS, I hereby release and forever discharge FOCOS, my past/present employer(s) and their respective parents, subsidiaries, and successors for any and all actions, which may result for any information that is lawfully provided concerning my past employment and/or present employment. I certify that all statements given on this application are correct with no omissions.

Applicant Signature

Date

Printed Name

Personal ID or Social Security Number

FOCOS is a 501©(3) tax exempt foundation.

Personal Health History Form

Privacy Notice: The primary purpose for soliciting this information is to determine medical eligibility for service abroad. The information on this form may be made available to appropriate staff. Failure to provide accurate information may result in changes to service status.

Complete Personal Health History and Physicals are mandatory for service with FOCOS and must be updated every 1 year.

To Be Completed by Applicant: (Please use black ink and print clearly in English)

Name: _____

Address _____

Country: _____

Phone: _____ (Home) _____ (Work)
_____ (Cell) Include **country code**

Date of Birth _____ **Age:** _____ **Gender** M ___ F _____

Position Applied for: _____ **Expected Duration of Service** _____

HAVE YOU EVER EXPERIENCED OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (PLEASE CHECK YES OR NO)

- | | |
|---|---|
| <p>Y___ N___ Frequent or severe headaches?
 Y___ N___ Dizzy spells, fainting, or blackouts?
 Y___ N___ Epilepsy or seizures?
 Y___ N___ Chronic eye trouble or vision problems?
 Y___ N___ Date of last eye exam?
 Y___ N___ Colonoscopy or sigmoidoscopy?
 Y___ N___ Kidney trouble, i.e. stones, blood, or protein in urine?
 Y___ N___ Diabetes?
 Y___ N___ Thyroid?
 Y___ N___ Asthma
 Y___ N___ Breathing trouble, i.e. frequent recurrent cough or shortness or breath?
 Y___ N___ TB, or exposure to TB?
 Y___ N___ Pain or pressure in your chest?
 Y___ N___ Anemia or another blood disorder?
 Y___ N___ Heart problems, murmur, or infection?
 Y___ N___ Stomach, liver, or intestinal problems?
 Y___ N___ Jaundice or hepatitis?</p> | <p>Y___ N___ Frequent indigestion?
 Y___ N___ Rupture or hernia?
 Y___ N___ Change in bowel or bladder habits?
 Y___ N___ Rectal bleeding or black stools?
 Y___ N___ Cancer?
 Y___ N___ Stroke?
 Y___ N___ Difficulty with hearing?
 Y___ N___ Urinary problems or urinary tract Infections?
 Y___ N___ Back pain or injury?
 Y___ N___ Bone, tendon or joint problems?
 Y___ N___ Abnormal chest xray?
 Y___ N___ Malaria, dysentery or other tropical disease?
 Y___ N___ Frequent crying spells?
 Y___ N___ Felt unusually depressed or sad?
 Y___ N___ Persistent fatigue?
 Y___ N___ Any other medical problems not already mentioned</p> |
|---|---|

History Form, continued

Do you smoke or chew tobacco?
 If so, what and how much? _____

Do you drink alcohol?
 If so, how much? _____

Would you have a problem with walking up six flights of stairs at a steady pace without stopping?

Would you have a problem walking a distance of approximately 1.5 miles (3km) on a level plane at a steady pace without stopping?

Have you EVER been referred to or sought consultation or treatment from mental health professional (counselor, psychologist, psychiatrist, social worker, pastoral, or family marriage counselor?)

Have you EVER received mental health treatment as an inpatient or as an outpatient in a day treatment center?

If you answered **yes** to any of the questions in this section, please explain here. If you need more space, please attach additional sheets:

Please list hospitalizations, operations and medical evacuations, including both medical and psychiatric illnesses:

Date	Illness or Operation	Name of hospital	Location	Duration of Treatment

Please list any current or past congenital or chronic conditions.

Medications: List all current

Name	Dosage	Frequency

Allergies: Drugs and Others

- Requirements:**
- Yellow fever: Required for all volunteers serving in West Africa; must be obtained before arriving.
 - Hepatitis B: Required for all volunteers serving in West Africa and health care services.

Please consult your primary doctor or travel clinic regarding your specific needs for the countries where you will be traveling for his/her recommendations. If you choose NOT to obtain any of the recommended vaccines FOCOS cannot provide them once you are approved. Please bring your vaccination record with you.

Health Insurance:

All serving overseas are required to provide proof of adequate health insurance which includes emergency evacuation, before arriving in Ghana. Please note that pre-existing conditions may impact this process. If you have a pre-existing condition and do not have health insurance you will need to obtain insurance that will cover you for this condition before serving with us. Our preferred evacuation insurance provider is Medjet. For more information please visit their website at www.medjet.com.

I, _____, have completed this form to the best of my knowledge. I also understand the need to report changes in my health status or treatment rendered by a physician prior to my joining FOCOS.

Authorization & Consent for Treatment: Please read carefully:

I request that this personal Medical History & Physician Evaluation be forwarded to the FOCOS Medical Advisory Committee and I hereby consent to the transfer to the United States all data contained in this application and any attachments thereto, including all private personal data. I also request that this personal Medical History & Physician Evaluation be forwarded to the FOCOS operating location where I will be serving in order that I may be given medical attention should that become necessary or appropriate.

I certify that all statements given on this application are correct with no omissions.

Additionally: IN the course of my service with FOCOS, I require medical treatment while outside my country, I hereby agree to the performance of such treatment, anesthetics, operations as, in the opinion of the attending physician, are deemed necessary.

Applicant Signature

Date

Friend Reference Form

Please fill in your name and address and give to a friend to complete:

Name of Applicant: _____

Applicant's mailing address _____

FOCOS has operated a growing clinic in Ghana since 1999. Applicants who serve are often subjected to physical and emotional stresses, which should be considered in your evaluation of their personal capabilities within FOCOS.

How long have you known the applicant? _____

Please evaluate the applicant in the following areas:

Character:

Skills, abilities, strengths, and talents:

Emotional stability:-

Do you have any reservations regarding this person's service with FOCOS?

Your Name _____

Address: _____

Title: _____ Organization: _____

Telephone Home/Cell/Work _____

Email _____

Signature _____ (Printed Name) _____

Date: _____

Employer Reference Form

Please fill in your name and address and give to your employer to complete:

Name of Applicant: _____

Applicant's mailing address _____

FOCOS has operated a growing clinic in Ghana since 1999. Applicants who serve are often subjected to physical and emotional stresses, which should be considered in your evaluation of their personal capabilities within FOCOS.

How long have you known the applicant? _____

Please evaluate the applicant in the following areas:

Character:

Skills, abilities, strengths, and talents:

Emotional stability:-

Do you have any reservations regarding this person's service with FOCOS?

Your Name _____

Address: _____

Title: _____ Organization: _____

Telephone Home/Cell/Work _____

Email _____

Signature _____ (Printed Name) _____

Date: _____

Physical Evaluation Summary Sheet

Importance of Examination: It is important for the examiner to identify all medical conditions which will require follow-up medical care or could be adversely affected by environmental conditions, such as air pollution or poor sanitation. The consequences of not identifying preexisting health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be assigned to a developing country where sophisticated medical care is not available, or will live in an area which can be very physically demanding at times. All reports must be in English.

Date of Exam: _____

Name: _____

Date of Birth _____ Age _____ Height _____ Weight _____ lb/kg.

Blood Pressure _____ Pulse _____

	Normal	Abnormal	Notes
Skin (record lesions, marks, scars, etc)			
Head, Neck, Thyroid			
Ear, Nose, and Throat			
Hearing			
Eyes (acuity, color perceptions)			
Lungs			
Breasts			
Heart (record murmurs and abnormalities)			
Genitalia			
Anus, rectum, and Prostate			
Vascular System (record peripheral pulses and varicosities)			
Extremities and spine			
Neurological (reflexes and muscle strength)			
Psychiatric			
Gynecological (note last normal exam)			

Additional Comments:

Recommendation for treatment/further follow up:

Physician's Signature

Date

Printed Name and address

Telephone: _____ Email address _____