

PLEASE NOTE: Volunteers who are not medical personnel serve RAM in many valuable support roles. However, it is necessary to fill all expedition teams with professional providers first, particularly for international expeditions.

For office use only: ___ L
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REMOTE AREA MEDICAL® VOLUNTEER APPLICATION

RAM Organizers should contact you approximately four weeks prior to the expedition(s) you choose to attend. Please feel free to contact our office if you have not received confirmation from RAM within this timeframe.

Due to a high volume of mail and a small staff, we are unable to acknowledge receipt of all applications. For further details on specific expeditions, please contact RAM at laurak@ramusa.org.

PLEASE TYPE OR PRINT CLEARLY

NAME _____ BIRTH DATE _____ TODAY'S DATE _____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

_____ CELL PHONE _____

FAX NUMBER _____ E-MAIL ADDRESS _____

PROFESSION / SPECIALTY(IES) _____

CERTIFICATE / LICENSE #s _____ Exp: _____ DEA # _____ Exp: _____

(Please include a copy of licenses/certifications with application; you will also be asked to bring a copy to each clinic you attend.)

HAVE YOUR PROFESSIONAL PRIVILEGES EVER BEEN SUSPENDED/REVOKED/
RELINQUISHED? _____

(If yes, please attach a one page explanation of the situation and its resolution.)

EXPEDITION(S) YOU EXPECT TO ATTEND: _____

BEFORE submitting your application, please refer to the RAM schedule elsewhere in this website and list at least one clinic you are interested in attending!

FOREIGN LANGUAGE (S) _____

PASSPORT EXPIRATION DATE _____ PLACE PASSPORT ISSUED _____

(International expeditions only)

(International expeditions only)

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE # 1 _____ PHONE # 2 _____

BLOOD-BORNE PATHOGENS TRAINING IS REQUIRED FOR ALL REMOTE AREA MEDICAL® VOLUNTEER **MEDICAL** PERSONNEL (*especially* volunteers working in the dental area). I hereby certify that I have completed a training / educational program dealing with the risks of exposure to bloodborne pathogens and methods to prevent exposure.

Print Name _____

Signature _____

RELEASE AND INDEMNIFICATION

I hereby release and indemnify Remote Area Medical, Inc., which is a non-profit corporation, and all its respective officers, directors, agents, contractors, employees, heirs, successors and assigns from prosecution or presentation of any claim for bodily injury or death or for property loss or damage incurred in connection with Remote Area Medical, Inc., expeditions or related activities. Intending to be legally bound, I have hereunto set my hand this

_____ day of _____, 20____. Signature: _____

Please send completed application & photocopies of current medical licenses or certificates (for international expeditions, also include an updated resume and a passport size photograph) to:

REMOTE AREA MEDICAL, 1834 BEECH STREET, KNOXVILLE, TN 37920 OR

Fax: 865-609-1876 OR E-mail: laurak@ramusa.org