ALLIANCE FOR SMILES INTERNATIONAL, INC.
Application for Non-Medical Volunteer

The following documents must be included with this application:

- *Photocopy of Passport*
- *Cover Letter and Resume (Please include how you heard about AfS, how you would like volunteer for us, and your skills/qualifications.)*

Send all documents to:

Alliance for Smiles
2565 Third Street Suite 237
San Francisco, CA 94107

IDENTIFYING INFORMATION

Last Name:	First Name:	Middle Name:
Any other name under which you have been known? Name(s):		

Home Address:	City:	
	State:	Zip:
Home Telephone Number: ( )	Cell Phone Number: ( )	
E-mail:	Second E-mail :	
Birth Date:	Male ☐	Female ☐
Emergency Contact:	Emergency Contact Telephone Number: ( )	
Complete name as shown on Passport:	Nationality:	
Passport Number:	Date of Expiration:	

WORK INFORMATION

Office Address:	City:	
	State:	Zip:
Telephone Number: ( )	Fax Number: ( )	

COMMITMENT TO ALLIANCE FOR SMILES INTERNATIONAL, INC.

Alliance for Smiles has made a long-term commitment to treating cleft anomalies in under-served areas of the world. Are you interested in making a similar commitment?

Volunteers will be required to pay their own travel expenses as specified by our travel agent. Do you agree to do so?

Each volunteer is required to pay a tax-deductible $350 Mission Participation Contribution and a $30 Travel Health Insurance Fee.
Do you agree to do so?

Do you speak any languages besides English? Are you fluent?

Prior medical missions you have gone on (if any):

Are you a Rotarian? If so, how long? Club name/location & district:

Do you have any medical conditions we should be aware of? (attach additional sheets if needed)

Do you take prescribed medications? (optional)

There will be times when you will be asked to wear an Alliance for Smiles t-shirt or polo shirt that will identify you as a team member.
Please indicate your shirt size (in men's sizes):

PERSONAL REFERENCES

LIST TWO PERSONAL REFERENCES:

REFERENCE # 1		
Name of Reference:	Title:	Telephone Number:
Address:	City:	
	State:	Zip:

REFERENCE # 2		
Name of Reference:	Title:	Telephone Number:
Address:	City:	
	State:	Zip:

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSIONS FROM THIS APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR AFFILIATION WITH ALLIANCE FOR SMILES INTERNATIONAL, INC. I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED TO ALLIANCE FOR SMILES INTERNATIONAL, INC. IN THIS APPLICATION AND IN ANY ACCOMPANYING DOCUMENT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Print Name: ____

Signature: ____ Date: __________________

Note: All volunteers must get vaccinated for hepatitis A and B before participating in a mission.