

 MINISTRY OF HEALTH	BAHAMAS Hurricane Dorian Response, 2019	MEDICAL VOLUNTEER
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Full Name	First	Last	MI
Date and Time of Offer	dd / mm / yyyy	HH:MM	

Internal Office Use Only			
Volunteer Status:	<input type="checkbox"/> Approved	<input type="checkbox"/> Pending	Reason:
	<input type="checkbox"/> Tasked	<input type="checkbox"/> Declined	Reason:
Allocated Site:	<i>Location</i>	<i>GPS Coordinates</i>	Allocation Date: dd / mm / yyyy
Other Comments:	<i>(e.g. reason for changing type vs the self-declaration from the team)</i>		

PERSONAL INFORMATION	
COUNTRY:	PROFESSIONAL TITLE:
TIME (HOURS/DAYS) OR ESTIMATED DATE OF ARRIVAL:	TIME (HOURS/DAYS) TO START OF SERVICES PROVISION:
ADDRESS:	
EMAIL:	PHONE: + <u>country</u> - <u>area</u> - <u>phone number</u>
LOCAL PHONE:	SATELLITE PHONE:

VOLUNTEER ACTIVITY
Please type in one paragraph the type of collaboration offered

LOGISTIC SUPPORT

Any logistical limitations or support required:

NO **YES** **Specify** (e.g. transport should include total volume and weight).

Self-sufficient during the whole mission

PREVIOUS DEPLOYMENT EXPERIENCE (ONLY LAST THREE)

YEAR	COUNTRY	EVENT	TYPE OF RESPONSE	DURATION (DAYS)

EXISTING OR PREVIOUS WORKING RELATIONSHIP IN BAHAMAS

ORGANIZATION	LOCATION	RELATIONSHIP

<p>DOCUMENTS REQUIRED</p> <p><input type="checkbox"/> Professional Practice License</p> <p><input type="checkbox"/> Copy of Passport</p> <p><input type="checkbox"/> Curriculum Vitae</p> <p><input type="checkbox"/> Medical Council</p> <p><input type="checkbox"/> Nursing Council</p> <p><input type="checkbox"/> Bahamas Health Professions Council</p>	<p>NAME:</p> <p>Email:</p> <p>Signature:</p>
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