CAPITOL CITY MEDICAL TEAMS TEAM APPLICATION

(revised 3-21-17)

Please complete the team application form and return it to:

Capitol City Medical Teams, 3275 Crestview Dr. S., Salem, OR 97302, or melabea@aol.com
If you have any questions, please contact Eric Miller at (503) 378-7343.

1. NAME OF TEAM LEADER, LEADER'S ADDRESS, AND PHONE NUMBER(S)

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_____

_____

2. EMAIL OF TEAM LEADER: _____

3. NAME OF LOCAL CONTACT, ORGANIZATION, PHONE NUMBER, EMAIL, AND ADDRESS WHERE WORK IS ANTICIPATED TO BE PERFORMED. (If it's at the Kausay Wasi Clinic, just write 'Kausay Wasi Clinic'.)

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4. TYPE OF TEAM (Check all that apply.)

___ Dental	___ ENT	___ General Medical
___ Ophthalmologic	___ Orthopedic	___ Plastics
___ Urology	___ OB/Gyn	Other _____

6. ESTIMATED NUMBER OF TEAM MEMBERS: _____

7. ANTICIPATED DATES OF WORK (Departure date to return date)

_____

Capitol City Medical Teams is not liable for equipment, supplies, or materials that are lost, stolen, or confiscated.

If there are complications with a patient that have resulted from your team's work, your team will be responsible for services and fees associated with the situation.

Teams are expected to bring or purchase all supplies needed for your trip. Arrangements may be able to be made for the host to purchase items, but the host will need to be reimbursed. Lab fees, x-rays, or other services will also be the responsibility of the team.

A trip report listing the number of patients seen, number and type of procedures performed, other statistical information, narrative, and a few <u>electronic</u> pictures with captions will need to be submitted within two months of the ending of the trip. Please see the Medical Campaigns section on our website at www.ccMedicalTeams.org for examples.

Please email a tentative list of team members' names, roles, and email addresses, so that Capitol City Medical Teams can distribute information to team members.

_____ _____

Signature of Team Leader Date of Signature