

CAPITOL CITY MEDICAL TEAMS TEAM APPLICATION

(revised 3-1-12)

Please complete the team application form and return it to:

Capitol City Medical Teams, 4950 Chauncey Court SE, 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)

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'.)

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

<input type="checkbox"/> Dental	<input type="checkbox"/> ENT	<input type="checkbox"/> General Medical
<input type="checkbox"/> Ophthalmologic	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Plastics
<input type="checkbox"/> Urology	Other _____	

6. ESTIMATED NUMBER OF TEAM MEMBER: _____

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 or stolen on the trip. Consideration for reimbursement may be made only if the Capitol City Medical Teams procedures were followed to prevent theft or loss.

A trip report listing the number of patients seen, procedures performed, other statistics information, narrative, and a few pictures 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 the team members.

Signature of Team Leader

Date of Signature