



Andrew N. Swanson, MD, Alumni Traveling Fellowship Application

Thank you for your interest in applying to the Andrew N. Swanson, MD, Alumni Traveling Fellowship with FOCOS in Ghana, West Africa. We appreciate your willingness to participate in an upcoming mission trip. The FOCOS mission is to improve the quality of life of patients in need throughout Africa and other parts of the world by providing optimum orthopedic care. Please submit a statement describing your special interest and how you can contribute to FOCOS. Along with the application, please submit two letters of reference and all of the documents on the checklist below. The Physical Evaluation Summary Sheet (page 9) should be completed by a physician and signed and dated appropriately.

The entire package can be emailed to **osheac@hss.edu** or interoffice mailed to Colleen O'Shea, MPA, Manager, Alumni Affairs, Education & Academic Affairs, 535 East 70th Street, New York, NY 10021.

CHECKLIST- Before your application is mailed; please ensure that you have all the required documents.

- Completed application
- Personal statement
- Resume signed and dated
- Copy of certified education certificates and diplomas
- Copy of information page of passport and birth certificate
- A valid medical or professional license to practice.
- Two letters of reference on official letterhead
- Two passport pictures (upon selection)

Before applying please read the following information: Applicants must be least 18 years old and in good health. All residents/fellows are expected to pay for their own flights to Ghana plus any additional costs connected to the trip (i.e. visa and vaccination costs). The Hospital will reimburse the selected Resident/Fellow for their travel expenses. Residents/Fellows will be responsible for providing their own travel and health insurance. If you do not have sufficient coverage, a basic plan can be purchased through Med-jet insurance (<http://www.medjetassist.com/>). Residents/Fellows will be responsible for ensuring they receive the appropriate vaccinations for visiting Ghana prior to their trip. Yellow fever and Hepatitis B are required for all volunteers serving in West Africa and must be obtained before arriving. You will be required to provide documentation of vaccinations to customs upon arrival in Ghana. Residents/Fellows can apply for one or two weeks of work in clinics or the operating rooms during mission trips at the FOCOS Hospital.

Once we receive your application, the Andrew N. Swanson, MD, Fellowship Committee and the FOCOS Medical Advisory Committee will review your application and supporting documents. If accepted, detailed information upon the position and/or mission trip will be sent to you via email. **PLEASE MAKE TRAVEL ARRANGEMENTS ONLY IF YOU HAVE RECEIVED AN ACCEPTANCE EMAIL AND CONFIRMED DATES OF SERVICE.**

Andrew N. Swanson, MD, Alumni Traveling Fellowship Application

1. First Name_____ 2. Middle Name_____ 3. Surname_____

4. Address_____

5. City_____

6. Zip/postal code_____

7. Email_____

8. Home Phone_____

9. Work_____ 10. Cell_____

11. Date of Birth_____

Emergency contact:

12. Name_____ 13. Address_____

14. Telephone_____ 15. Email_____

16. Dates you are interested in volunteering_____

17. Length of time_____

18. Have you applied to FOCOS before? Yes_____ No_____

19. Do you have friends or relatives who have served with FOCOS? If yes, who?

20. Are you able to raise the funds to serve with FOCOS (i.e. flights to/from Ghana, costs for vaccinations)?

Yes_____ No_____

21. Have you been convicted of a criminal offense? Yes_____ No_____

If yes, please explain_-----

22. Are there any circumstances (medical or other) which could interfere with your meeting the requirements of the position you are applying for?

Yes_____ No_____

If yes, please explain_-----

Medical Health Information

The primary purpose of obtaining this information is to determine medical eligibility for service abroad. The information on this form may be made available to appropriate staff. Failure to provide accurate information may result in changes to the volunteer role. Have you experienced or are currently experiencing any of the following (please circle yes or no):

Frequent or severe headaches	Yes	No
Dizzy spells, fainting and blackouts	Yes	No
Epilepsy or seizures	Yes	No
Chronic eye trouble or vision problems	Yes	No
Date of last eye exam	Yes	No
Colonoscopy or sigmoidoscopy	Yes	No
Kidney trouble i.e. stones, blood or protein in urine	Yes	No
Diabetes	Yes	No
Thyroid	Yes	No
Asthma	Yes	No
Breathing trouble i.e. frequent cough or shortness of breath	Yes	No
TB or exposure to TB	Yes	No
Pain or pressure in your chest	Yes	No
Anemia or another blood disorder	Yes	No
Heart problems, murmur or infection	Yes	No
Stomach, liver or intestinal problems	Yes	No
Jaundice or hepatitis	Yes	No
Frequent indigestion	Yes	No
Rupture or hernia	Yes	No
Change in bowel or bladder habits	Yes	No
Rectal bleeding or black stools	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Difficulty with hearing	Yes	No
Urinary problems and urinary tract infections	Yes	No
Back pain or injury	Yes	No
Bone tendon or joint problems	Yes	No
Abnormal chest x-ray	Yes	No
Malaria, dysentery or other tropical disease	Yes	No
Frequent crying spells	Yes	No
Felt unusually depressed or sad	Yes	No
Persistent fatigue	Yes	No
Any other medical problems not mentioned	Yes	No
Do you smoke	Yes	No
If yes what and how much?	_____	N/A

Do you drink alcohol?	Yes	No
If yes how much?	_____	N/A
Would you have a problem walking a distance of approximately 1.5 miles (3km) on a level plane at a steady pace without stopping?	Yes	No
Have you ever been referred to or sought consultation or treatment from a mental health professional (counselor, psychologist, social worker etc.)	Yes	No
Have you ever received mental health treatment as an inpatient or as an outpatient in a day treatment center?	Yes	No

If you answer yes to any of the questions in the above section please explain here. If you need more space, please attach additional sheets:_____

Please list hospitalizations and operations including both medical and psychiatric illnesses:

Date	Illness/ Operation	Name of hospital	Location	Duration of treatment

Current Medications: List all

Name	Dosage	Frequency

Please list any allergies: Drugs and others_____

Please consult your family care doctor or travel clinic regarding your specific needs for the countries where you will be travelling. **Yellow fever and Hepatitis vaccines are required for all volunteers serving in West Africa—without these vaccinations you will be unable to get a VISA to enter Ghana.** Please bring your vaccination record with you.

Authorization and Consent for Treatment: Please Read Carefully

I _____ have completed this personal Medical Health Information form (pages 3, 4, 5 and 6) to the best of my knowledge. I also understand the need to report changes in my health status or treatment rendered by a physician prior to joining FOCOS. I consent to this information being shared with the Medical Advisory Committee and FOCOS Ghana and USA, if deemed necessary. If I require medical treatment while volunteering with FOCOS in Ghana, I hereby agree to the performance of such treatment, anesthetics, operations, that in the opinion of the attending physician, are deemed necessary.

Electronic Signature

Date

Dear Prospective Resident/Fellow:

Thank you for interest in the Andrew N. Swanson, MD, Alumni Traveling Fellowship. Prior to making a commitment to FOCOS however, you should be advised and in agreement with the following risks.

If you are a medical provider and intend to provide medical services, you should be aware of medical malpractice issues. Please know that although FOCOS maintains the Standard Ghana professional indemnity coverage in Ghana, this insurance may not extend to you for any malpractice claim brought against you personally. We strongly urge that you contact your individual malpractice insurance provider and inquire as to coverage. If you are insured for malpractice in the Hospital Sponsored Professional Liability Insurance Program (MIAC), you must contact Risk Management to discuss your coverage prior to your trip.

On another note, you should be made aware that patients in Ghana are not always tested for HIV, however, should a “needle stick” occur, testing will be done at that time. Moreover, FOCOS is prepared to provide onsite drug administration prior to returning to your home country where treatment can continue. Precaution is the best policy regarding handling of sharps and surgical technique.

Lastly, while traveling as a FOCOS volunteer, you assume the same risks as you would if traveling personally. As such, FOCOS cannot be responsible for any theft and/or personal injury that may occur during your travels. It is suggested that you familiarize yourself with any and all insurances pertaining to same.

Historically, these issues have not been a problem and rarely encountered, however, it is necessary to advise you of the foregoing. FOCOS thanks you for your interest and anticipated participation in the FOCOS Volunteer Program.

FOCOS Board of Directors

Electronic Signature

Date

Physical Evaluation Summary Sheet- FOR A PHYSICIAN TO COMPLETE

Important of Examination: It is important for the examiner to identify all medical conditions which will require follow-up medical care or could be adversely affected by environmental conditions, such as air pollution or poor sanitation. The consequences of not identifying pre-existing health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be assigned to a developing country where sophisticated medical care is not available, or will live in an area which can be very physically demanding at times. All reports must be in English.

Date of Exam:_____ Patient Name: _____ Date of Birth:_____

Age:_____ Height:_____ Weight:_____ Blood pressure:_____ Pulse: _____

	Normal	Abnormal	Notes
Skin			
Head, Neck, Thyroid			
Ear, Nose and throat			
Hearing			
Eyes			
Lungs			
Breasts			
Heart			
GU			
GI			
Vascular System			
Extremities and spine			
Neurological (reflexes and muscle strength)			
Psychiatric			
GYN			

Please include a list of patient's medications: _____

Comments/recommendations for treatment/further follow-up:

Physician's signature _____ Date _____

Print name and address _____

Telephone _____ Email address _____