



American Physicians and Friends for Medicine in Israel

2001 Beacon Street, Suite 210, Boston, MA 02135

EMERGENCY MEDICAL VOLUNTEERS FOR ISRAEL

I am a Physician Nurse Other Health Care Professional _____ (Specify)

First Name _____ Last Name _____

Address _____

City _____ State/Province _____ Zip/Postal Code _____

Telephone (h) _____ (w) _____ Fax _____

Beeper _____ Cell phone _____

Email _____

Year of Birth _____ Marital Status _____ Number of Children _____ Citizenship _____

In case of emergency, contact _____ Telephone _____

1. **LICENSING:**

State Medical License # _____ Expiration Date _____

State Nursing License # _____ Expiration Date _____

Federal DEA License # _____ Expiration Date _____

2. **CERTIFICATION:**

Certified by American Board of _____ Date _____

If not certified, please provide present status in certification process on a separate sheet of paper.

3. **MEDICAL SPECIALTY:** _____ **Sub Specialty** _____

4. **TRAINING:**

Have you completed any of the following training (please check all that apply)

ATLS ACLS PALS BLS

5. **RESIDENCY INSTITUTION** _____ **Year Completed** _____

6. **HEALTH:**

Do you presently have a physical or mental health condition that may affect your ability to travel?

Yes No

If yes, please provide details on a separate sheet of paper.

Past medical history: list medication, allergies on a separate sheet of paper.

Primary Care physician: _____ Telephone: _____

Notification necessary to be available in time of emergency:

2 days 7 days 14 days 30 days 60 Days

Availability of time to be a medical volunteer in Israel

14 days 30 days 60 days 3 month or more

Please indicate any prior working familiarity with a particular Israeli hospital

Name of Hospital _____ City _____

Fluency in Hebrew

Fluent Good Fair Poor None

➤ Please turn over and complete Form

American Physicians Fellowship for Medicine in Israel

Phone: (617) 232-5382 - Fax: (617) 739-2616 - E-mail: info@apfmed.org - Website: www.apfmed.org



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PLEASE READ CAREFULLY AND ATTACH COPIES OF THE FOLLOWING WHEN SUBMITTING YOUR APPLICATION TO APF.

WE WILL NOT BE ABLE TO PROCESS YOUR APPLICATION WITH THE MINISTRY OF HEALTH IN ISRAEL FOR PRE-CERTIFICATION WITHOUT THESE DOCUMENTS.

Copies of documents that need to be NOTARIZED

- Current State License
- Original License
- Specialty Certification(Board Certification)
- Federal DEA License
- Medical School Diploma
- Passport Photo Page

Copies of documents that do not need to be notarized

- Curriculum Vitae
- Letter of Good Standing from your Hospital/Medical Institution(make sure it states you are in "Good Standing")

Signature _____ Date _____

Thank you for your support of the Emergency Medical Volunteer Program in Israel.

2011/j:emv/Biographical form2011

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