Medical Mission Application Form

Please complete, save and email this application along with an attached copy of your curriculum vitae to: apo@cacha.ca

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel. Home #: _____ Tel. Work #: _____

Tel. Mobile #: _____ Tel. Fax #: _____

E-mail Address: _____
(*Please print your email carefully*)

A $500 non-refundable deposit will be charged upon acceptance to a specific mission
Credit card info (type, number, exp. date, security code, name on card):
_____

Professional designation (if applicable): _____

Professional license number (if applicable): _____

Organization: _____

Mission of interest(s):

□ Benin □ TZ Terrat □ TZ PTE □ TZ Shirati □ TZ Ukerewe □ Uganda

Departure(s):_____
(DD/MM/YYYY)

Role of interest:
□ Surgeon □ Physician □ Nurse □ Pharmacist
□ Dentist □ Logistics □ Other: _____

Have you ever participated in a CACHA medical mission before?

□ YES □ NO

If YES, please provide us with the most recent mission name & date:
Mission: _____

How did you hear about CACHA? _____

Motivation for participating in a CACHA mission:

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