Cleft Surgery Training Program: APPLICATION

NAME (LAST, FIRST MIDDLE):____

PROFESSIONAL TITLE / EDUCATIONAL LEVEL OF TRAINING: _________________________
____

INSTITUTIONAL AFFILIATION: ____

APPLICANTINFORMATION

HOME PHONE:(country code _____) _______________ MOBILE: (____) _____________

FAX: (_____) _____________ EMAIL: ______________________________________

PERMANENT ADDRESS:____
____

CITY: ____________________STATE:______________ POSTCODE:___________

COUNTRY:______________________________________

[ ] PHYSICIAN CURRENT INFORMATION

SURGICAL SPECIALTY: ____

CURRENT POSITION:____

INSTITUTION:____

CITY:__________________ STATE:_______________ COUNTRY:_____________

SUPERVISOR:____

SUPERVISOR PHONE:____

SUPERVISOR EMAIL:____

[ ] PHYSICIAN TRAINING INFORMATION

SURGICAL SPECIALTY: ____

INSTITUTION:____

CITY:__________________ STATE:_______________ COUNTRY:_____________

DATES OF ATTENDANCE: ____

DATE OF COMPLETION: ____

CERTIFICATE: ____

PROGRAM DIRECTOR:____

PROGRAM DIRECTOR PHONE:____

PROGRAM DIRECTOR EMAIL:____

[ ] MEDICAL SCHOOL INFORMATION

MEDICAL SCHOOL: ____

CITY:______________________ COUNTY:_________________ COUNTRY:______________

DATES OF ATTENDANCE: ____

DATE OF COMPLETION: ____

CERTIFICATE: ____

[ ] TIME PREFERENCE

Please indicate your top THREE time frames for the fellowship. Fellowships are four complete months each, with three total time periods available in a calendar year:

1. **JANUARY – APRIL**
2. **MAY – AUGUST**
3. **SEPTEMBER – DECEMBER**

Preference #1:___________________________Year: __________
Preference #2:___________________________Year: __________
Preference #3:___________________________Year: __________

Do you have experience with Mission Smile or other cleft charities? ☐ *YES* ☐ *NO*

If YES, please explain: ____
____

Have you ever participated in any regional outreach or overseas medical / healthcare work?

☐ *YES* ☐ *NO*

If YES, please explain: ____
____

Please briefly describe your experience with cleft lip and cleft palate. An honest self-appraisal is most helpful for instructors to understand the current skill set of applicants in order to tailor educational activities to the appropriate level.

1. Unilateral Cleft Lip
Explanation: ____
____

Cases done in training:	Cases done in last year:	Cases done last 5 years:	Cases done in career:
Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___

Confidence Level with Unilateral Cleft Lip:	
Knowledge:	1 2 3 4 5
Surgical Technique:	

2. Bilateral Cleft Lip
Explanation: ____
____

Cases done in training:	Cases done in last year:	Cases done last 5 years:	Cases done in career:
Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___

Confidence Level with Bilateral Cleft Lip:	
Knowledge:	1 2 3 4 5
Surgical Technique:	

3. Cleft Palate
Explanation: ____
____

Cases done in training:	Cases done in last year:	Cases done last 5 years:	Cases done in career:
Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___	Assist: ___Surgeon: ___

Confidence Level with Cleft Palate:	
Knowledge:	1 2 3 4 5
Surgical Technique:	

4. Secondary Cleft Surgery
Explanation: ____
____

CURRENT EXPERIENCE: Please indicate which types of patients/programs you have had experience with in the last 3-5 years, and describe your current work.

_____ Pediatrics (0-6 years old)	_____ Youth (7-14 years old)	_____ Adult (over 14 years old)

Please briefly describe the nature of your current work:

____
____
____
____

SUPPLEMENTARY DOCUMENTATION	
Please attach the following REQUIRED documents:	**CHECK THIS COLUMN WHEN COMPLETED**
Curriculum vitae	☐
Color passport style photograph.	☐
****IMPORTANT**: Non Indian residents will need to obtain a PASSPORT and official VISA FOR INDIA on his or her own. A **color copy** of the **PASSPORT** including the **VISA, complete and stamped into the applicant's passport**, is required to be submitted to GC4 if the applicant is selected, after their acceptance, and **PRIOR to arrival in Guwahati**. Please sign here that you understand this future requirement: Applicant Signature: ______________________________ Date: __________________*	☐ ☐ **N/A**
Copy of medical or dental school diploma	☐
Copy of plastic surgery or maxillofacial training diploma	☐
Copy of additional training certificate(s) -- optional	☐
ESSAY: Please attach a ONE PAGE essay describing why you want to participate in the Cleft Surgery Training Program in Guwahati. Please include your goals and expectations from the fellowship as well as your specific plans for treating patients with cleft lip and cleft palate in underserved regions. Also please discuss any aspirations you have to contribute to Mission Smile.	☐
LETTERS OF REFERENCE: Please attach THREE letters of recommendation from separate individuals, including at least two from other physicians, who are familiar with the your qualifications, interests, and commitment to cleft surgery.	☐ ☐ ☐

LANGUAGES SPOKEN (Including English)	**LEVEL OF PROFICIENCY (Select: Basic, Intermed., Fluent, or Native Speaker)**

LAST NAME:	DATES REQUESTED:

STATEMENT OF RESPONSIBILITY	
Please read and initial these sections to indicate your agreement:	**INITIAL**
I understand that Mission Smile's Cleft Surgery Training Program is centered around an agenda of service, education, leadership, and research aimed at developing a specialized skill set that will include excellence in cleft care and expertise in provision of surgical care in resource-challenged settings.	
I understand that CSTP is a multi-disciplinary program, supported by experts in the fields of cleft surgery, ENT, speech therapy, orthodontics and social areas involved in the recruitment, treatment and follow up of patients with cleft lip and cleft palate. I further understand that participation with each of these specialties is a necessary part of the program in order to improve my grasp of comprehensive care for patients, from first registration of the patient through post-surgical follow up treatment.	
I understand that it also expected that participants are involved with research efforts at GC4, where numerous studies are consistently underway.	
I understand that the ultimate goal of the CSTP is to develop cleft surgeons committed to improvement of surgical delivery in areas of high need, who will in turn make immediate and long term contributions to underserved populations in regions of need.	
I understand that the CSTP will include intensive clinical training in the outpatient clinic, the inpatient ward, the operating room, and in the field. As a fellow I will work with the GC4 team, assisting in the planning, treatment, and aftercare of patients. Surgical fellows will participate in all aspects of care delivery, and will have mentoring provided by credentialed GC4 attending surgeons at all times.	
I understand that surgeon mentors are responsible for education and supervision of the fellows, and overseeing and guiding the process of graded responsibility that characterizes training at GC4. I understand that increased autonomy inside and outside of the operating room is based on progressive clinical performance, and is at the discretion of clinical faculty mentors.	
I understand it is my responsibility to ensure I remain within the boundaries of my role. I further agree that failure in any aspect of my responsibilities constitutes sufficient reason for my immediate dismissal from the medical project at my personal expense.	
I fully agree that it is my responsibility to maintain at all times compliance with all Policies and Procedures of the Guwahati Comprehensive Cleft Care Center, and with the Mission Smile International Global Standards of Care.	

I have read the above and certify that all completed portions of the foregoing application are true, correct and complete. I shall promptly inform Mission Smile if there is any change to the facts herein.

Applicant Printed Name:____

Applicant Signature:____________________________________**Date:** ______________

LAST NAME:

Please read, initial the appropriate sections as they apply to your current professional / educational level of training, and sign and date the following:	**INITIAL**
Acknowledging that Mission Smile wishes to protect the rights of its patients, follow all ethical considerations governing their right to privacy, and requires all of its partners to adhere to the highest ethical principles, and in consideration of being given access to information that will be valuable in supporting the efforts of Mission Smile in the area of the state of Assam, India, I,___________________________________, agree to the following: *[print full name here]*	
(1) The information to be disclosed to me is described as: basic demographic patient information, images of patients, and *all* interactions with Mission Smile patients both in and outside of the Guwahati Comprehensive Cleft Care Center in Guwahati, India. As a fellow, I will also be disclosed information described as: clinical techniques and practices of Mission Smile physicians, nursing staff, and support staff.	
(2) I agree to keep in confidence and to use the information solely for the purposes of clinical care of patients and for the education of myself and any Guwahati Comprehensive Cleft Care Center staff, and internal reporting to Mission Smile offices and to government entities involved and authorized by Mission Smile to partake in patient recruitment and treatment. This information is not to be used or any other purposes without Mission Smile's prior written consent.	
(3) I further agree to keep in confidence and not disclose any part of the information to any party not involved in the work of Mission Smile and its partners. All oral disclosures of information, as well as written information, are covered by this agreement.	
(4) I agree to obligate my peers, colleagues, employees, and whoever else to which this is applicable: who have access to any portion of the information provided, to protect its confidential nature.	
(5) I agree to respect this agreement and understand that it is inspired by the need to protect the patient's rights to privacy and the ethical practices following the principles of autonomy, non-maleficence, beneficence, and justice.	

I have read the above and certify that my initials and signature signify my understanding of and compliance with the above.

Applicant Printed Name:____

Applicant Signature:____**Date:** ________________