



American Physicians Fellowship For Medicine in Israel

2001 Beacon Street, Suite 210, Boston, MA 02135-7771

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 _____ Email _____

Beeper _____ Cell phone _____

Citizenship _____ Passport # _____

Year of Birth _____ Marital Status _____ Number of Children _____

In case of emergency, contact _____ Telephone _____

1. **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 medications, allergies on a separate sheet of paper.

Primary Care physician: _____ Telephone _____

2. **LICENSING**

State Medical License # _____ Expiration Date _____

State Nursing License # _____ Expiration Date _____

Federal DEA License # _____ Expiration Date _____

3. **CERTIFICATION**

Certified by American Board of _____ Date _____

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

4. **MEDICAL SPECIALTY** _____ **SUB SPECIALTY** _____

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

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 months or more

Fluency in Hebrew

Fluent Good Fair Poor None

Please indicate any prior working familiarity with a particular Israeli hospital

Name of Hospital _____ City _____

Please turn over and complete form →

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

1. Current State License
2. Original License
3. Specialty Certification (Board Certification)
4. Federal DEA License
5. Medical School Diploma
6. Passport Photo Page

Copies of the documents that do not need to be notarized

7. Curriculum Vitae
8. Letter of Good Standing from your Hospital/Medical Institution (make sure it states you are in "Good Standing")
9. Passport Size Photo

IF YOU DO NOT WISH TO BE PRE-CERTIFIED BY THE MINISTRY OF HEALTH, PLEASE RETURN THIS FORM, AND THE INDEMNITY FORM, TO THE APF OFFICE AND YOU WILL BE PLACED ON THE EMV REGISTRY. SHOULD THERE BE A DECLARED EMERGENCY IN ISRAEL, AND THE REGISTRY ACTIVATED, IF YOU ARE NOT PRE-CERTIFIED, YOU WILL NEED TO TAKE ALL THE NOTARIZED AND NON-NOTARIZED DOCUMENTS WITH YOU.

I hereby certify that I have active and unrestricted hospital privileges at _____.
I will provide documentation of these privileges upon request.

Signature _____ Date _____

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



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CONSENT, INDEMNIFICATION, RELEASE, AND WAIVER OF LIABILITY

On behalf of myself, my spouse, children, heirs, beneficiaries, executors and administrators, in exchange for receiving permission from American Physicians Fellowship for Medicine in Israel ("APF") to provide volunteer services under the auspices of the APF Emergency Medical Volunteer Program (the "EMV Program"); and understanding and acknowledging that I will be required to travel, live, work and perform tasks in countries where I may be subjected to considerable risks, including, but not limited to, the risks of international travel, terrorism, civil unrest and exposure to disease;

I do hereby **CONSENT** to participate in the EMV Program on the terms and conditions herein stated, and do hereby **ASSUME** all of the risks, both foreseeable and unforeseeable, associated with such participation, and do hereby **INDEMNIFY, RELEASE, WAIVE LIABILITY** and **FOREVER DISCHARGE** and **HOLD HARMLESS** APF, its affiliates, and each of their respective officers, directors, employees, agents, volunteers, successors and assigns (collectively, the 'Indemnitees'), from and against any and all losses, liabilities, actions, claims and demands of any nature, past, present or future, including, without limitation, reasonable attorneys' fees and court costs, that may result from or in any way relate to my participation in the EMV Program.

1. I understand that this Agreement is a release, indemnification and a waiver of liability for the benefit of the Indemnitees and that by this Agreement I am assuming the risks of traveling to, living and working in such foreign countries as APF may select in order to participate in the EMV Program. I understand that I will be traveling and working in areas where health and sanitation practices may be below United States standards.
2. I understand that the parties I am releasing may hereafter make mistakes, commit acts or otherwise fail to do things which may cause my death, injury, illness or loss of property or other serious harm. I am assuming that risk; and if such should occur, it is my loss and I understand that this release and waiver releases the Indemnitees from any liability incident to such loss. I or anyone claiming under me cannot seek any damages, compensation or other remuneration from any of the Indemnitees for that loss. I understand that I am indemnifying and holding the Indemnitees harmless from and against any liability as a result of my voluntary participation in the EMV Program.
3. I understand that APF shall not provide me with insurance coverage of any kind and I have been advised by APF to secure my own insurance coverage in connection with my participation in the EMV Program.
4. I acknowledge that I am not an employee, officer or agent of APF or any of its affiliates within the meaning of any applicable federal, state or local law or regulation, or the laws or regulations of the State of Israel or any other foreign jurisdiction in which I may perform volunteer services for APF.
5. I expressly waive any claim asserting employee status under the laws or regulations of the State of Israel or otherwise asserting this Agreement is in any way governed by such laws or regulations.

6. I acknowledge that this Agreement shall be governed by, construed and enforced in accordance with the laws of the Commonwealth of Massachusetts without giving effect to the conflicts of laws principles thereof.
7. I consent to the non-exclusive jurisdiction of the federal and state courts located within the Commonwealth of Massachusetts to adjudicate any dispute that may arise under this Agreement or in connection with my participation in the EMV Program, and I hereby specifically consent to service of process by certified or registered mail at the address set forth below.
8. I agree that in the event that any term or condition contained in this Agreement shall for any reason be held by a court of competent jurisdiction to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other term or condition of this Agreement, but this Agreement shall be construed as if such invalid or illegal or unenforceable term or condition had never been contained herein.
9. I acknowledge that I have completely read and understood this document. I am signing this document freely and voluntarily and without any coercion or any influence of any kind. I acknowledge that there have been no promises, representations or inducements to my signing this document other than those set forth herein.

SIGNATURE

HOME ADDRESS

PRINT NAME

CITY, STATE AND ZIP CODE

DATE: _____