AGA KHAN HEALTH SERVICES TANZANIA

MEDICAL PLACEMENT FORM

1. GENERAL

Name (Last, First)	Home Telephone	Mobile Telephone	Work Telephone	Email Address
Mailing Address	City/Town	State/Province/Region	Zip/Postal Code	Country

2. EMPLOYMENT/SOCIAL/MEDICAL FIELD WORK

INSTITUTE/AREA	NATURE OF WORK	CITY, COUNTRY	DEPARTMENT	DATES EMPLOYED
				From: To:
				From: To:
				From: To:
				From: To:
				From: To:

3. EDUCATION

SCHOOL NAME (UNIVERSITY/COLLEGE)	CITY, COUNTRY	FIELD OF STUDY	DEGREE EARNED	YEAR GRADUATED

4. CERTIFICATIONS OR LICENSES

LICENSE/CERTIFICATION	PROFESSION	CITY, COUNTRY	EXPIRATION DATE

Other education/training/skills including computer experience

5 PASSPORT

Date of Birth	Place of Birth	Country of Citizenship	Passport Number
Place of Issue	Date of Issue	Date of Expiry	Additional Passport Information

6 EMERGENCY CONTACT

Name (Last, First, Middle Initial)	Home Telephone	Work Telephone	Mobile Telephone
Relationship	Email Address	City	Country

7 MEDICAL ELECTIVES IS TO ARRANGE FOR OWN OUT OF –COUNTRY TRAVEL & HEALTH INSURANCE

Do you currently have health insurance? Yes/ No travel insurance only		
If Yes, Health Insurance Company Name:	**Policy # :**	**Insurance Company Phone #**
For any I assignments, do you have any medical conditions that you would like to make AKHST aware of?		

8. INTERESTS

What type of volunteer experience are you looking for?
(Please check)

- ☐ Radiology
- ☐ Pediatric
- ☐ Internal Medicine
- ☐ Obs/Gynae
- ☐ Surgical
- ☐ Pharmacy
- ☐ Physiotherapy
- ☐ Pathology
- ☐ Dental

☐ Others:

9. AVAILABILITY (NWH: 8.00 – 4.30 – THIS MAY EXTEND TO AFTER OFFICE HOURS)

Start Date:

End Date

10. QUESTIONS OR COMMENTS:

Questions or comments :

DATE: _____

_____

NAME /SIGNATURE

FOR OFFICE USE ONLY

START DATE: _____

END DATE: _____

ID BADGE: _____

MEDICAL BY-LAWS: _____

VOLUNTEER AGREEMENT DATE: _____

OFFICE REGISTRATION NO: _____