



CATHOLIC MEDICAL MISSION BOARD

HEALING HELP PHARMACEUTICAL DONATIONS PROGRAM

Request Form

The following information is required by CMMB before a donation of pharmaceuticals or medical supplies can be provided to you or your organization. The answers to the following questions will provide us with an overview of your working situation and allow us to respond in the most appropriate way possible. Once you have completed and submitted the application, it will go through an internal review process and CMMB will determine if we are able to assist your program/mission and to what extent. We ask that you allow six weeks for processing.

Instructions: Please complete and return the following to:
Catholic Medical Mission Board (CMMB)
Attention: Kathy Tebbett
10 West 17th Street
New York, NY 10011
Fax: (212) 645-1485
Email: ktebbett@cmmb.org

CMMB ships much needed medicines and supplies to locations worldwide, in response to requests from our in-country partners. In addition, CMMB supports the efforts of those volunteers who organize medical mission trips by providing them with all the medicines they can carry as they go about their work.

- If you are organizing a medical mission trip, please submit the **Mission Team Profile** with the completed application.
- If you are requesting medicines and medical supplies to support an in-country healthcare facility, please submit the **Country Program Profile** with the completed application.
- If you are organizing a medical mission trip in support of an in-country healthcare facility, please submit both the **Mission Team Profile** and the **Country Program Profile** with the completed application.

Date _____

1. Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ Email: _____
State: _____ Website: _____
Zip Code: _____

2. Does your organization have a religious affiliation?

No: _____
Yes: _____ Please identify: _____

3. Is your organization registered as a 501 (c)(3) tax-exempt organization? If so, please provide us with your 501 (c)(3) form.

No: _____
Yes: _____

4. Name and contact information of the healthcare facility (dispensary, hospital, parish, mission site) which will be the recipient of the donation:

Name: _____ Phone: _____
Contact: _____ Fax: _____
Address: _____ Email: _____
City: _____ State: _____
Country: _____

5. How were you referred to CMMB? (check all that apply)

Mailing list: _____ Pharma company: _____
Personal reference: _____ Mission affiliation: _____
Internet: _____ Other: _____

6. Who is your targeted population?

Adults: _____ # Children _____ # Males _____ # Females _____

7. What are the immediate diseases that afflict your targeted population? Please list.

8. Describe the healthcare facility that provides treatment for the affected population?

Clinic: _____ Dispensary: _____ Hospital: _____ For profit/private: _____
Non profit/charitable: _____ Government: _____

9. Indicate what type of treatment the healthcare facility provides:

Emergency _____ Surgery _____
Pediatrics _____ Dentistry _____
X-ray _____ Laboratory _____
OB/GYN _____ Pharmacy _____

Orthopedics _____ Hospice _____
 Phys Therapy _____ Nutrition _____

10. Indicate the hours of operation of the facility, if known.

11. List the number and type of staff at the facility, if known.

Medical Doctor (if specialist, please identify specialty) _____
 Surgeon _____ Dentist _____
 Nurse _____ Other _____
 Health workers _____ Non-medical _____

12. Please provide an itemized list of the products needed, including medicines, medical supplies, and hygiene items.

- ♣ Please classify items, for example, by: Antacids, Antibiotics, Antifungals, Antihelminthics, Antihistamines, Antihypertensives, Hormonal, Ophthalmic, Respiratory, Topicals, Analgesics, Antivirals, Cough/Cold, Diabetic, GI, Miscellaneous, or Vitamins.
- ♣ Please give the names of the products, quantities requested, and expiry requirements.
- ♣ Please provide information on any other requirements for product donations.
- ♣ A separate list detailing this information is suggested.

13. In order to receive a donation of CMMB medicines and medical supplies you must acknowledge your agreement to comply with the following terms and conditions by reading each statement and signing your initials in the space provided:

- ♣ All CMMB donations must be distributed free of charge and without discrimination of any nature, including politics, religion, and geographic location.
- ♣ A modest administrative fee for service is acceptable, but this fee must not be identified with the CMMB medicines or supplies provided. _____
- ♣ I will not return any donation to the United States. _____
- ♣ I will not sell or exchange any donation for property or services. _____
- ♣ I will immediately notify CMMB of any diversion, loss or destruction of products. _____
- ♣ I will confirm receipt of all donations by returning the shipment manifest shipping and delivery receipt provided by CMMB with each donation. _____
- ♣ I will provide CMMB with acknowledgements, photographs, including reports, distribution grids, or program evaluations. _____

14. In order to receive a donation of CMMB medicines and medical supplies you must acknowledge your acceptance of CMMB's Mission and Vision statement by reading the statements and signing in the space provided:

Our Mission

Founded in 1928 and rooted in the healing ministry of Jesus, Catholic Medical Mission Board works collaboratively to provide quality healthcare programs and services, without discrimination, to people in need around the world.

Our Vision

A world in which every human life is valued and quality healthcare is available to all.

Name, position & signature of the representative of the sponsoring organization

Name: _____ Signature: _____
Position: _____ Date: _____

15. Health Practitioner’s Statement of Intent for Use of Medicines and Health Care Supplies

This is to certify that I take full responsibility for donated medicines and supplies to be used in mission work outside of the United States. In compliance with the Food, Drug, and Cosmetic Act, as amended, and IRS regulations, these medicines and supplies will not be returned to the United States, nor be sold or exchanged for other commodities or services. They will be used in treating the sick poor, especially women and children. If these supplies are lost, misplaced, or stolen prior to arriving at their ultimate destination, I will immediately report this in writing to CMMB.

Name of Practitioner: _____
Signature of Practitioner: _____
State/Country of License: _____
License Number: _____

Profession: (check one)

Medical Doctor (if specialist, please identify specialty) _____
Surgeon _____ Dentist _____
Nurse _____ Other _____

Address: _____ Phone: _____
City: _____ Fax: _____
State: _____ Email: _____
Zip Code: _____ Country: _____

Mission Team Profile

A. What are the dates for your mission trip?

Start date: _____ **End date:** _____

B. List the number and type of volunteers who will be going on your mission:

Medical Doctor (if specialist, please identify specialty) _____
Surgeon _____ Dentist _____
Nurse _____ Other _____
Health worker _____ Non-medical _____

C. Indicate what type of treatment you will provide on your mission:

Emergency	_____	Surgery	_____
Pediatrics	_____	Dentistry	_____
X-ray	_____	Laboratory	_____
OB/GYN	_____	Pharmacy	_____
Orthopedics	_____	Hospice	_____
Phys Therapy	_____	Nutrition	_____

D. How long have you been organizing mission trips?

E. How often do you schedule trips?

Once a year _____ 2 x a year _____ Other _____

F. Please provide the contact information for where the donation is to be sent:

Name:	_____	Phone:	_____
Address:	_____	Fax:	_____
City:	_____	Email:	_____
State:	_____		
Zip:	_____		

G. Does CMMB need to provide any other documents to ensure delivery of medicines into the country?

No: _____

Yes: _____ Please specify: _____

H. Are you or your organization able to pay shipping costs (Fed Ex/UPS)?

No: _____

Yes: _____

Country Program Profile

A. Please give a detailed summary of the challenges faced by the healthcare facility.

B. How can these challenges be minimized by CMMB donations?

C. Please indicate the program in which the donations will be used.

D. How does the use of the donations in this program support your organizational mission?

E. Please indicate what other resources are needed to insure your sustainability and build your capacity for service.

F. Is the healthcare facility or your organization able to pay any of the following expenses related to this donation?

Ocean shipment:

No: _____ Yes: _____

Inland transportation:

No: _____ Yes: _____

G. Please acknowledge your agreement to the following statement by reading the statement and signing your initials in the space provided:

♣ I agree to incur any additional expenses related to demurrage, storage, inspection or clearance.

H. Is the healthcare facility able to receive donations duty free? _____

No: _____ Yes: _____

H. Does CMMB need to provide any other documents to ensure delivery of medicines into the country?

No: _____ Yes: _____

If YES, please specify:

I. Name and contact information of the individual or agency that will act as consignee and assist the facility in the clearance receipt and delivery of this donation:

Name: _____ Phone: _____
Agency: _____ Fax: _____
Address: _____ Email: _____
City/Town: _____ State/Region: _____
Country: _____

J. Give the details of the most convenient port of entry or airport for clearing the shipment through customs and for in-country transportation:

K. Do you have an import customs broker?

No: _____ Yes: _____

If YES, you must immediately start the process to obtain the duty/free import certificate with your government's minister of finance and when the certificate is issued we must be contacted. We cannot ship until this certificate is in place.

Please also provide the full name, address and contact of your customs broker:

Name: _____ Phone: _____
Address: _____ Fax: _____
City/Town: _____ Email: _____
State: _____ Zip code: _____

If NO, do you have the funds to pay for a broker if we hire a company to represent you?

No: _____ Yes: _____