Application for Fistula Repair Program

Please complete the following application. Direct any questions to the contact information below.

Direct Relief International, 27 S. La Patera Lane, Santa Barbara, CA 93117

Lindsey Pollaczek: lpollaczek@directrelief.org | 1-805-964-4767 x 108 phone

Required fields are marked with an asterisk (*). Applications that are missing required information will not be processed until the information is received.

Review Eligibility Requirements

Health facilities must meet the following criteria to apply for partnership. Eligible health facilities must:

- Provide services to patients in a non-discriminatory manner and must be provided free of charge, for a voluntary fee, or based on a patient’s ability to pay
- Be officially registered and licensed as an approved provider of health services in the country of service
- Have a fistula repair surgeon on site (or an established partnership with a visiting consultant) with a valid medical license
- Provide a minimum of 50 fistula repair surgeries each calendar year. Facilities with fewer surgeries that can demonstrate a clear plan for growth will also be considered.
- Have an unmet need for medical supplies and be able to describe how a donation of supplies would improve its ability to provide fistula repair services
- Have the ability to manage the process of clearing a donation of medical supplies through customs and overseeing in-country transport of supplies to a secure storage facility

I have read the Eligibility Requirements and agree that the organization for which I am applying meets the requirements.

Initials:  ______________

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SECTION 1: About Your Health Facility

1. **Applicant Information**
   Please fill in the contact details of the person completing this application.

   First Name*  
   Last Name*  
   Job Title*  
   Country of Residence*  
   Telephone*  
   Email*

2. **Health Facility Information**
   Please complete the information about the hospital where fistula repair surgery is provided. This is the facility where the medical supplies from Direct Relief would be utilized. If you would like to request assistance for more than one hospital, please complete a separate application for each facility.

   Health Facility Name*  
   Street Address 1*  
   City*  
   State or Region  
   Postal Code  
   Country*  
   Telephone*
3. Health Facility Type*
   Check all that apply.

   - Charitable/NGO
   - Faith-based
   - Government
   - U.S.-based 501(c)3
   - Other: ____________________________

4. Organization Information

If you do not work at the health facility listed above, please tell us about the organization you work for. If you work at the health facility listed above, please skip to question 6.

   Organization Name*
   ________________________________

   Street Address 1*
   ________________________________

   City*
   ________________________________

   State or Region
   Required for US
   _____________________________

   Postal Code
   Required for US
   ________________________________

   Country*
   ________________________________

   Telephone*
   ________________________________

   Website
   ________________________________
5. EIN/Tax ID Information

For organizations based in the United States: Per the IRS, to be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3), and none of its earnings may inure to any private shareholder or individual.

Employer Identification Number (EIN)* ____________________________ (XX-XXXXXXX)

Fistula Repair Services

6. Please briefly describe the need for fistula repair services in your country or region. Why did your health facility decide to start providing fistula care? *


7. What year did your health facility start providing fistula repair services?

8. Number of obstetric fistula repair surgeries at your health facility: *

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>In 2012</td>
<td></td>
</tr>
<tr>
<td>In 2013 (estimate)</td>
<td></td>
</tr>
<tr>
<td>In 2014 (estimate)</td>
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</tbody>
</table>

9. If you plan to increase the number of fistula repair surgeries in 2014 over the previous year, describe how you intend to reach your target:
10. Availability of fistula repair services at your health facility*  
   Check one.

☐ Fistula repair is a routine service that is available throughout the year

☐ Fistula repair is provided only during fistula repair camps/outreaches or when a fistula surgeon visits the hospital

☐ Other, please describe __________________________________________________

11. Please describe the availability and frequency of fistula repair services provided at your hospital (e.g. how many days per week, month, or year are fistula repair services available?) *


12. Type of surgical services provided by your hospital.*  
   Check all that apply.

☐ Simple Fistula Repair

☐ Complex Fistula Repair

☐ Simple RVF Repair

☐ Complex RVF Repair

☐ Surgery for urinary incontinence  
   Please name the most common procedure performed at your facility: ______________________

☐ Vaginal Reconstruction

☐ Skin Flaps

☐ Urinary Diversion

☐ Other, please describe: __________________________________________________________
13. Type of Non-surgical services provided by your hospital.
   Check all that apply.
   - Urethral plugs
   - Urodynamics
   - Medical therapy for incontinence
     Please describe ____________________________________________
   - Other, please describe ____________________________________

14. Number of beds at your health facility dedicated to fistula patients: *

15. If you conduct fistula camps/outreach, number of beds dedicated to fistula patients during these outreaches/ camps:

16. Please describe how your health facility currently collects and maintains fistula patient information. How is the information stored (in paper files, electronic database, etc) *
17. Please describe any rehabilitation or reintegration services provided at your health facility. If your facility does not directly provide these services, please describe if your facility works with other organizations to provide this care.


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Fistula Surgeon Capacity

18. How many fistula surgeons are based permanently at your health facility? *


19. Please list the names, years of practice, and estimated number of fistula repairs conducted by each fistula surgeon based at your facility: *

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Number of years of Practice</th>
<th>Estimated number of fistula repairs conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>5</td>
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</tbody>
</table>

20. In the past 2 years, has your health facility hosted visiting fistula surgeons to assist with cases?

[ ] Yes
[ ] No

21. If yes, Please list the name(s) of organization sponsoring the visit(s) and the name of the visiting surgeon(s)
22. Does your health facility train surgeons and/or staff involved with fistula repair? If so, please describe:


Cost of Treatment

23. Please provide the average cost for one fistula repair at your institution. * (US Dollars)
   For currency conversion, use http://www.oanda.com/currency/converter/


24. What percentage of the total cost of treatment is medicines and medical supplies? *


25. How does your health facility finance fistula repair services *
   Check all that apply.
   - [ ] Patient self-pay
   - [ ] Ministry of Health/Governmental support
   - [ ] Non-governmental support
   - [ ] Other, please describe ________________________________

26. If your institution receives non-governmental organization (NGO) support, please list the name(s) of organizations that provide support:


Medical Supplies for Fistula Repair

27. How does your health facility acquire the medical supplies needed for fistula repair? *
   *Check all that apply.*
   
   ☐ Supplies are purchased locally
   
   ☐ Supplies are purchased abroad and imported through customs
   
   ☐ Supplies are provided by the Ministry of Health
   
   ☐ Supplies are donated by a NGO/charitable organization
   
   ☐ Other: ____________________________

28. Approximately what percentage of the medicines and medical supplies at your health facility are:*
   *Please indicate the percentage for each category.*
   
   ☐ Purchased by your institution
   
   ☐ Supplied by the Ministry of Health
   
   ☐ Donated by an NGO/Charitable organization
   
   ☐ Other: ____________________________

29. If any of the supplies are donated by an NGO/charitable organization, please list the name(s) of the organization and briefly describe the type of supplies:

   ____________________________
30. Please briefly describe your experience obtaining supplies for fistula repair. For example, how difficult is it to obtain the necessary supplies? Do you have challenges with the quality of medical supplies? Do you frequently stock out of particular medicines or supplies for fistula repair, if so which supplies do you frequently stock out of? *

31. Please describe how your health facility would benefit from a donation of medical supplies from Direct Relief*

Clinical Oversight

32. Head of Department: Please provide the name of the physician In-charge of the Fistula Unit

First Name*

Last Name*

Country of Issue*

33. Medical License

Please attach a copy of the Head of Department's medical license or document authorizing medical practice. A current and valid medical license is required before shipments are sent.
34. Shipping / Consignee Address*

Please enter the primary address to which you would like product shipped. This is the consignee which will receive the shipment at the port of entry, clear it through customs, and arrange for its transportation to the recipient facility.

☐ Same as the Health Facility Address (Skip to question 34)

☐ Add new address (proceed to question 33)

35. Add New Address: Shipping / Consignee

Please provide the name and location that would receive shipments for distribution to this facility. This is the consignee which will receive the shipment at the port of entry, clear it through customs, and arrange for its transportation to the recipient facility. Please make edits and/or fill in the required text entry boxes.

Organization/Facility Name*

__________________________________________

Street Address*

__________________________________________

City*

__________________________________________

State or Region

__________________________________________

Postal Code

__________________________________________

Country*

__________________________________________

Telephone*

__________________________________________

Fax

__________________________________________
36. Storage Capacity*

Please mark the choices which describe the storage capacity of the location receiving donations of medicines and medical supplies.

- Storage space is a warehouse
- Storage space is on-site at the medical facility
- Storage facility has capacity to store cold chain products

37. Ocean Port of Entry*

What is the preferred port of entry?


38. Airport of Entry*

What is the preferred airport of entry?


39. Minimum Shelf Life Upon Arrival*

What is the minimum shelf life required upon arrival that this facility can accept and process through customs?

- months
References
Please provide two (2) independent references that are familiar with the organization's work.

Reference #1
Prefix*  
First Name*  
Last Name*  
Telephone  
Email  
Relationship*  
Organization

Reference #2
Prefix*  
First Name*  
Last Name*  
Telephone  
Email  
Relationship*  
Organization

How did you hear about Direct Relief International?*

☐ Colleague or Personal Reference:  

☐ Direct Relief Employee or Board Member:  

☐ Internet Search  

☐ Magazine/Newspaper Advertisement  

☐ Other:  

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Medical Donations Program Agreement

BACKGROUND AND TERMS OF USE FOR DONATIONS

Direct Relief is a U.S.-based, non-profit medical relief and health assistance organization that is dedicated to serving the poor and victims of natural disasters and civil strife in the United States and throughout the world. Assistance is provided by distributing donated medical goods to charitable health care institutions and organizations. Direct Relief is non-sectarian and non-political, and requires that your organization render services at its clinics to all persons regardless of nationality, political affiliation, ethnic origin, religious belief or ability to pay. Your organization must assume full responsibility for the non-commercial use and distribution of the donated products and must ensure that no one is turned away due to the inability to pay for medical treatment.

PLEDGE

Your organization agrees to distribute all donated medical goods and related access to services, including, without limitation, pharmaceuticals, equipment and supplies (collectively, “Medical Products”) received from Direct Relief strictly on the basis of need and without regard to race, religion, nationality, ethnic origin, or political affiliation, and in no case will your organization withhold any Medical Products from needy persons because of their inability to pay for services.

Your organization agrees to assume full responsibility for the non-commercial use and distribution of this donation.

Your organization further understands that the Medical Products that are being donated by Direct Relief are to be dispensed to uninsured low-income individuals who are patients of your organization’s medical services. Your organization will abide by all applicable federal and local regulations in the dispensing of these Medical Products. Your organization agrees and acknowledges that the Medical Products will neither be sold nor traded, nor returned to the original manufacturer for credit.

Your organization is responsible for the proper disposal of any unused or expired pharmaceuticals, equipment and supplies and shall abide by all federal or local regulations as may be applicable.

Your organization understands and agrees that in providing the donated Medical Products, Direct Relief does not act as a seller, re-seller or manufacturer for purposes of products liability law or for any other purpose.

Direct Relief reserves its rights to conduct an inspection of your organization’s facilities and records to ensure full compliance with this Agreement.

Your organization, if approved to receive donations, will be required to sign a Memorandum of Understanding stipulating terms of the Agreement.

Authorized Signatures

By entering my name below, I attest that the information provided with this application is true and accurate and understand and agree to the terms in the above agreement.

Name*  

Date*  
