

## Pioneer Madagascar Programme

### Volunteer Application Form



In order to apply for a placement on a Pioneer Programme, please provide us with the information set out on this form. Please either type into this form (an expandable Word format version is available to download from [www.madagascar.co.uk](http://www.madagascar.co.uk)) or simply complete clearly by hand. Please use as much space as you need.

Please note that we do not pass on your private information to any other person or organisation not directly associated with Azafady management. We will use the information provided on this form to assess your suitability for the Pioneer Programme and this may include us obtaining a medical opinion from the Azafady team doctor. We will use this information to contact you with information relating to your Pioneer volunteering experience and/or to contact your friends and/or family in an emergency. By completing this form you are giving us your permission to use the information that you provide for the purposes mentioned above. If you do not wish us to use your personal information for the reasons set out above, please do not continue to complete the form.

When complete, please send a signed hard copy to:

**Pioneer, Azafady, Suite 7, 1a Beethoven Street, London W10 4LG U.K.**

*Please ensure that you answer all questions fully as gaps in information may delay the processing of your application.*

#### **General Information:**

1. Family name (Last Name)
2. Other names (First Name)
3. Occupation
4. Date of birth
5. Male / Female
6. Nationality
7. Address for correspondence
8. Day telephone (please include international codes)
9. Evening telephone
10. Fax number
11. Email address

12. Permanent address (if different to above)

13. Have you been convicted of any criminal offence in the last 5 years? Criminal convictions can have a bearing on your ability to obtain a visa. Please note that the Rehabilitation Act of 1974 (Exceptions) Order 1975 (as amended) states that you do not generally have to disclose details of spent convictions. Please note we may request you to undertake a Criminal Background Check if accepted onto the Pioneer Programme.

14. Do you have any criminal proceedings pending?

15. Give details if yes to 13 or 14 above

16. We welcome applications from disabled people. If disabled give details.

17. We currently have four 10-week programmes each year commencing in January, April, July & October. For which do you wish to apply? Please give your first and second choices, as programmes fill quickly.

1<sup>st</sup> choice:

2<sup>nd</sup> choice:

18. Have you ever applied to us before for a volunteer placement?

19. Do you have financial commitments (e.g. student loan, mortgage, child maintenance)? If yes, please explain how you intend to cover them while you are in Madagascar.

20. Please describe your marital status.

21. Do you have children? If yes, please give details.

**Education/Work Experience/etc.:**

**\*\*Please attach your C.V./Resume to the application form\*\***

22. Explain as fully as possible why you are applying for this placement.
23. How do you feel you will benefit from the Pioneer programme? What do you expect to gain from it?
24. What particular education/relevant experience do you have that will be useful during the placement?
25. Please list any practical skills that you have and beside each please indicate whether you have (a.) basic ability, (b.) good practical ability or (c.) could train others in that skill. (e.g. plant identification, farming, etc.)
26. Please list any teaching skills that you have and give details.
27. Do you speak another language? If so, what?
28. Is there any work that you would not be prepared to do?
29. Please provide the name, address, contact telephone number & email address of two character witnesses who are not your relatives, one of which should know you in a professional or academic capacity. Please note that we will contact both of these referees and your participation on Pioneer will be subject to Azafady receiving two adequate references from them.
- i)
- ii)
30. There is a prerequisite that a donation be made to Azafady to fund your placement (please see website). How might you raise this money?

**31. Health Information:**

**Before filling out the following section, please read the following excerpt from the Memorandum of Understanding that you will be expected to sign to confirm your place:**

Malaria is a serious problem in Madagascar and in some cases it can be life-threatening. The villages where Azafady work are pathogen-rich environments and there is potential to contract various illnesses when working in them. These villages are isolated and it may take up to 24 hours before you can receive medical attention. The regional hospital in Fort Dauphin is basic and if more complicated treatments are required it will be necessary to be evacuated. We recommend you consider these facts when deciding which immunisations to undertake or medication to bring.

By confirming my place on Pioneer, I agree to follow health protection advice that I have gained from a qualified travel health professional. This will include a vaccination programme and a malarial prophylaxis regime:

The malarial prophylaxis I will take will comply with World Health Organisation guidelines. I understand that alternative or homeopathic prophylaxis regimes are unacceptable whilst I am working with Azafady in Madagascar. N.B. It is Azafady's experience that over 40% of Pioneers who choose to take Doxycycline suffer unacceptable sun-sensitivity which affects their ability to work.

All volunteers must be vaccinated against Tetanus to participate in the Pioneer Programme. We also advise you to be vaccinated against Typhoid, Meningitis, Hepatitis A & B, Rabies and Polio but up to date professional advice must be sort.

We may disclose any health or medical information provided to us to our insurers to ensure continued cover on your behalf. Please note that if you take out additional cover, it is your responsibility to inform your insurance company of any pre-existing medical conditions or your insurance may be found to be invalid.

Please answer all the questions in Table 1. For every question you answer yes to, please complete a separate copy of **Form A** to provide details.

**Table 1**

| Do you currently or have you ever suffered from ..... |                                                                           |     |    |
|-------------------------------------------------------|---------------------------------------------------------------------------|-----|----|
| 1.1                                                   | Asthma                                                                    | Yes | No |
| 1.2                                                   | Tuberculosis                                                              | Yes | No |
| 1.3                                                   | Any disease/ problems affecting your breathing/ ear/ nose/ throat         | Yes | No |
| 1.4                                                   | Hypertension (high blood pressure)                                        | Yes | No |
| 1.5                                                   | Heart disease, heart failure, rheumatic or valvular disease               | Yes | No |
| 1.6                                                   | Heart attacks or angina                                                   | Yes | No |
| 1.7                                                   | Arrhythmia, palpitations or any disease/ problems affecting the heart     | Yes | No |
| 1.8                                                   | Epilepsy                                                                  | Yes | No |
| 1.9                                                   | Migraine                                                                  | Yes | No |
| 1.10                                                  | Vertigo or dizziness                                                      | Yes | No |
| 1.11                                                  | Strokes, mini strokes, blackouts or any neurological disease/ problems    | Yes | No |
| 1.12                                                  | Anaemia or other blood disorder                                           | Yes | No |
| 1.13                                                  | Diabetes, hypothyroidism or any other endocrine disease/ problems         | Yes | No |
| 1.14                                                  | Arthritis, rheumatism or gout                                             | Yes | No |
| 1.15                                                  | Back pain, lumbago, sciatica or neck pain                                 | Yes | No |
| 1.16                                                  | Any other joint, bone or muscle disease/ problems                         | Yes | No |
| 1.17                                                  | Eczema or psoriasis                                                       | Yes | No |
| 1.18                                                  | Hay fever                                                                 | Yes | No |
| 1.19                                                  | Hives, urticaria or any other disease/ problems affecting the skin        | Yes | No |
| 1.20                                                  | Gynaecological disorder/ problems                                         | Yes | No |
| 1.21                                                  | Emotional difficulties including depression, anxiety or panic attacks     | Yes | No |
| 1.22                                                  | Mental illness                                                            | Yes | No |
| 1.23                                                  | Behavioural difficulties including ADHD, hyperactivity                    | Yes | No |
| 1.24                                                  | Any other major illnesses                                                 | Yes | No |
| 1.25                                                  | Any operations                                                            | Yes | No |
| 1.26                                                  | Any other conditions needing hospital, general practitioner or other care | Yes | No |
| 1.27                                                  | Have you needed to attend A&E in the last 3 years                         | Yes | No |
| 1.28                                                  | Any allergy to any medicine                                               | Yes | No |
| 1.29                                                  | Any allergy to insect bites                                               | Yes | No |
| 1.30                                                  | Any other allergy                                                         | Yes | No |

**Form A**

Please ensure you have completed a **separate** form A for every question for which you answered **yes** in Table 1. Give as much detail as possible and attach additional information if necessary.

|                                                                                                                                                                                                                                                                               |                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Name of condition/diagnosis:                                                                                                                                                                                                                                                  |                                                   |
| When did it start/ get diagnosed:                                                                                                                                                                                                                                             |                                                   |
| Is it an ongoing problem? <i>If <b>yes</b>, please explain how often you are affected by this condition.</i>                                                                                                                                                                  | Yes    No                                         |
| If not, then when did it last affect you/ stop?                                                                                                                                                                                                                               |                                                   |
| Please explain in as much detail as possible the symptoms of your condition and how it manifests itself?                                                                                                                                                                      |                                                   |
| Have you ever been admitted to hospital for this condition? <i>If <b>yes</b>, please give details and dates.</i>                                                                                                                                                              | Yes    No                                         |
| Have you ever attended A&E or needed emergency treatment for this condition? <i>If <b>yes</b>, please give details and dates.</i>                                                                                                                                             | Yes    No                                         |
| Is your condition exacerbated by any other factors? (e.g. exercise, stress, other illnesses etc.) <i>If <b>yes</b> please give as much detail as possible.</i>                                                                                                                | Yes    No                                         |
| Do you need to take any precautions because of your condition? <i>If <b>yes</b> please give as much detail as possible.</i>                                                                                                                                                   | Yes    No                                         |
| Will Azafady need to make any special arrangements in relation to your condition during your time in Madagascar? (e.g. medical access, medication availability etc.) <i>If <b>yes</b> please give as much detail as possible.</i>                                             | Yes    No                                         |
| Are you taking any medicine for this condition?                                                                                                                                                                                                                               | Yes    No                                         |
| Have you ever taken any medicine for it?                                                                                                                                                                                                                                      | Yes    No                                         |
| <i>If you have answered <b>yes</b> to either of the last two questions, please give details:</i><br><br>Name of medicine:<br><br>Type of medicine (e.g. anti-inflammatory, pain killer etc.):<br><br>Dosage:<br><br>Can you take a 90 day supply of this medication with you? | <br><br><br><br><br><br><br><br><br><br>Yes    No |

**Table 2**

Please note that **every applicant** must answer **all** below questions: 2.1 to 2.5

|     |                                                                                                                                                                                                                                                                                                                                                                                                |     |    |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 2.1 | <p>Are you taking any medicines in addition to those that you have declared on Form(s) A? <i>If yes, please give the following details:</i></p> <p>Name of medicine:</p><br><p>Type of medicine (e.g. anti-inflammatory, pain killer etc.):</p><br><p>Dosage:</p><br><p>Condition for which medication is being taken:</p><br><p>Can you take a 90 day supply of this medication with you?</p> | Yes | No |
| 2.2 | Do you have any objections to taking any medicines?                                                                                                                                                                                                                                                                                                                                            | Yes | No |
|     | <i>If you have answered <b>yes</b> to question 2.2 please give further details.</i>                                                                                                                                                                                                                                                                                                            |     |    |
| 2.3 | Do you intend to take a World Health Organisation approved malaria prophylaxis (e.g. Larium, Doxycycline, Malarone)?                                                                                                                                                                                                                                                                           | Yes | No |
| 2.4 | Will your GP practice be prescribing that for you?                                                                                                                                                                                                                                                                                                                                             | Yes | No |
|     | <i>If you have answered <b>no</b> to any of questions 2.3 – 2.4 please give further details.</i>                                                                                                                                                                                                                                                                                               |     |    |
| 2.5 | Have you considered that 40% of our previous volunteers who chose Doxycycline have had to stop taking it because of a rash? They have had to arrange emergency courier supplies of alternatives to be flown out to them from their home country at their own expense.                                                                                                                          | Yes | No |

**Table 3**

Please note that **every applicant** must answer **all** below questions: 3.1 to 3.7

|     |                                                                                                                                                                |     |    |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 3.1 | Can you manage being isolated from your usual family and friends while working with a small group of people for up to 10 weeks in remote and basic conditions? | Yes | No |
| 3.2 | Can you walk up to 10 km over the course of a day in hot tropical conditions?                                                                                  | Yes | No |
| 3.3 | Can you live on a basic but nutritionally balanced diet often consisting of rice and beans for up to 10 weeks?                                                 | Yes | No |
| 3.4 | Can you manage with being 24 hours away from the nearest medical care or doctor with only the most basic facilities?                                           | Yes | No |
|     | <i>If you have answered <b>no</b> to any of questions 3.1 – 3.4, please give further details.</i>                                                              |     |    |
| 3.5 | Do you have any objection to Azafady contacting your doctor?                                                                                                   | Yes | No |
| 3.6 | Do you have any objection to Azafady contacting your next of kin?                                                                                              | Yes | No |
| 3.7 | Is there any other medical or health information you wish to inform us of?                                                                                     | Yes | No |
|     | <i>If you have answered <b>yes</b> to any of questions 3.5 – 3.7, please give further details.</i>                                                             |     |    |

| Doctor's Contact Details                            |  |
|-----------------------------------------------------|--|
| Doctor's Name:                                      |  |
| Name & Address of Medical Practice:                 |  |
| Telephone Number:                                   |  |
| Fax Number:                                         |  |
| How long have you been registered at this Practice: |  |



**Other:**

32. Do you have any special dietary requirements? Please give details. If vegetarian, please indicate what sort of vegetarian. For example, do you eat fish?

33. Is there anything else that you would like to tell us?

34. How did you hear about Azafady / Pioneer? Please select all relevant boxes and give as many details as possible:

☐ **Advertising** – eg Big Issue, The Guardian, Poster, other publication

Please state which:

☐ **Word of mouth** – eg previous Pioneer/ other contact (please give name)

Please give their name:

☐ **University** – eg careers fair, e-mail, careers office, poster

Please state how:

☐ **Internet search** – eg GVI, Changing Worlds, African Impact, Career Break Site, Responsible Travel, Google search

Please state which website/organisation:

☐ **Other**

Please specify:

35. In an emergency, apart from your insurer, whom would we contact? Please provide as many details as possible including email address and telephone / fax numbers for day and night.

**Please now sign the following declaration and post this entire application form to our address below. We suggest you keep a copy of your application as you will need it for your visa. Applications can also be e-mailed to [info@azafady.org](mailto:info@azafady.org) However, we will need a signed, hard copy of your application prior to your arrival in Madagascar.**

Thank you for completing this application.

Send to:

**Mark Jacobs, Pioneer, Azafady, Suite 7, 1a Beethoven Street, London W10 4LG U.K.**

### **Declaration**

I declare that to the best of my knowledge the information I have given in this application form is correct.

- I declare that I have never been convicted of a sexual offence, or dismissed from a post working with children, the elderly or disabled for malpractice.
- I will not hold Azafady liable in any way for any accidental or medical emergency that occurs. I understand that I am covered as part of the Azafady Company Travel Insurance Policy arranged by Insurance Linx Limited and underwritten by Lloyd's and will, in due course, read the details of this policy and undertake to purchase additional cover should I require
- I understand that once I arrive in Fort Dauphin then Azafady may only cancel the programme in the case of an act of god or civil disturbance which would cause danger to my or other persons' security if the programme were to continue. I understand that I may be required to pay additional costs to repatriate myself and confirm that I will obtain insurance to cover such costs.
- I agree to behave appropriately with cultural sensitivity and due consideration for other volunteers, Azafady staff and local communities. I understand that I will be asked to leave the programme if my behaviour is regarded as: repeatedly inappropriate or anti-social, a gross misconduct, bringing the organisation into disrepute or the personnel and/or other volunteers into danger.
- I agree to action medical advice gained from a qualified travel health professional with respect to an appropriate vaccination programme and W.H.O. recommended malaria prophylaxis.
- I understand that the Pioneer programme lasts for ten weeks commencing upon my arrival in Fort Dauphin Madagascar and at the end of that ten-week period Azafady is no longer in anyway responsible for providing me with meals, accommodation or assistance should I choose to remain in Madagascar until the end of the 90 day visa.

I understand that, if accepted, Azafady has the right to ask me to leave the programme at any time, without any course to compensation or refund of any monies paid or donated, if I fail to comply with these and any other conditions detailed on the Memorandum of Understanding that I will be required to sign to confirm my place. I understand that if I am asked to leave the programme then Azafady may choose to contact the Malagasy authorities and my visa to remain in Madagascar may be withdrawn without notice.

Signature: .....

Date: .....