SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration

NURSES

First Time

- **Professional Registration for Short-Term Volunteers Form:**
  - Registrar section: "Nursing Council of Jamaica"
  - Your name, profession, dates of trip, working in "St. Mary rural clinics"
  - Local contact person or sponsor: "San San Win, MD; Director of Health, St. Mary"
- **Work Permit Exemption Application Form:**
  - Check the exemption box, complete items 1-8
  - Item 9 is your social security number
  - Complete items 10-14
  - Sign item 29
- **Blue Form:**
  - Fill out as instructed
- **Curriculum Vitae (Resume)**
- **Certified copy of Birth Certificate***
- **Certified copy Marriage Certificate***
  - If Diploma name is different from License name
- **Certified copy of Certificate/Diploma from School of Nursing***
- **Certified copy of current nursing license***
- **Certified copy of front page of passport***
- **Two (2) written references from Nursing Supervisors**
- **Two (2) passport-sized photographs**

*This packet is comprised of SAMPLE filled out forms.

Returning

- **Short-Term Volunteer Form (see instructions above)**
- **Work Permit Exemption Application Form (see instructions above)**
- **Updated Curriculum Vitae (Resume)**
- **Certified Copy of Current License***
- **Certified copy of front page of passport* (if renewed)**
- **Two written references from Nursing Supervisors**
- **1 passport-sized photograph**

Nursing students

- **Short-Term Volunteer Form (see instructions above)**
- **Work Permit Exemption Application Form (see instructions above)**
- **2 passport-sized photographs**
- **A letter from the University verifying status of student(s)**
- **Certified copy of front page of passport***

** Certified copies are made by taking your original documents along with the copies to a notary and having them certify with their stamp*

PROFESSIONAL REGISTRATION FOR SHORT TETRM VOLUNTEERS

All doctors dentists, pharmacists, nurses, dieticians, radiographers, medical technologists, speech, occupational and physical therapists must be registered with their respective Council before practicing their professions in Jamaica, even if only for a day. (Also needing registration are dental hygienists, technicians)

Medical Council
2-4 Kings Street
Kingston, Jamaica
Tel: (876) 922-3529/967-1549

Dental Council
41 Main Street
Mandeville, Jamaica
Tel; (876) 962-6488

Council Professions Supplementary to Medicine
2-4 Kings Street
Kingston, Jamaica
Tel: (876) 922-3529/967-1549

Nursing Council
The Towers
25 Dominica Drive
Kingston 5, Jamaica
Tel: (876) 926-6042

No Council will give this 'special' registration unless they are confident that the period of volunteer service is recommended by both the local health authority and the respective head of the Department of Ministry of Health. The whole process will be facilitated if the form below is filled out and signed (by applicant, of sponsor for him/her, local and head office authorities) and sent with credentials and application form to the respective Council as above.

A small registration or processing fee is charged.
The local health authority is the Medical Officer (Health)

SHORT TERM VOLUNTEER

Your Name
Your Address
Applicant's Address

Date ← Date

REGISTRAR
Nursing **COUNCIL OF JAMAICA**
I Your Name apply for special registration
As a Nurse in order to volunteer my service
Profession
For the period of (trip dates) at St. Mary rural clinics
Dates (specific) **Facility/Location**
In the (civil) parish of St. Mary

My local contact person is:
NAME: Dr. San San Win, MD; Director of Health, St. Mary
ADDRESS: Port Maria Hospital, Port Maria PO, St. Mary, Jamaica, WI
TEL: (876) 994-2358

(leave blank)
Sponsor's Signature

Leave blank

I recommend the above

Signature | Position Local Health Authority | Date

Signature | Position Head Office, Ministry of Health | Date

★ Be sure to check the "EXEMPTION" Box

MINISTRY OF LABOUR AND SOCIAL SECURITY

WORK PERMIT/EXEMPTION APPLICATION FORM

Foreign Nationals and Commonwealth Citizens Employment Act 1964)

Please indicate the type of application: ☐ **Work Permit** ☒ **Exemption**

PART I **TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

1. First Name	Last Name	Middle Initial	Alias
John	DOE	A.	

2. Address (overseas, except in the case of renewal)	3. Gender	4. Date of Birth	5. Country & Place of Birth
home address	☒ Male ☐ Female	1970/12/03 YYYY/MM/DD	USA - OH

6. Nationality	7. Number Of Children/ Dependents	8. Marital Status
American	2	☐ Single ☐ Divorced ☐ Widowed ☒ Married ☐ Separated

9. TRN	10. Occupation	11. Period for which Permit/Exemption is required YYYY/MM/DD
Social Security #	Nurse	From_____ To_____ Blank

12. Passport Number	13. Passport Expiry Date YYYY/MM/DD	14. Type of Passport (Country Issued)
123456789	2020/07/12	USA

15. Qualification – Academic or Professional (Attach Documentary Evidence)	**Details on previous (Last) Employer in Jamaica**
Blank	20.Name of Employer
	21. Address of Employer
16. Work Experience	22. Telephone Number
	23. Applicant's Work Permit Number / 24. Expiry Date YYYY/MM/DD
17. Skills of Applicant	**Details of Husband's/Wife's previous Employment in Jamaica**
	25. Name of Employer
18. Husband/Wife's Name	26. Address of Employer
19. Husband/Wife's Nationality	27. Work Permit Number / 28. Expiry Date YYYY/MM/DD

Blank

29. I certify to the best of my knowledge and belief, that the above information is correct

★ Date Here YYYY/MM/DD — Date

★ Sign Here — Applicant's Signature

* Blank *

PART 11 TO BE COMPLETED BY PROSPECTIVE EMPLOYER

30. Business Name/Name of Employer/Sponsor	38. TRN
31a. Business Address (Post Office Box # not acceptable) Street City Parish	39. Tax Compliance Certificate (TCC)
31b. Mailing Address (if different from above)	40. Is your Company registered? Yes No 41. Date of Registration YYYY/MM/DD
32. Telephone Number 33. Fax number	42. The request for Work Permit/Exemption is in relation to: Bi/Multilateral Agreement ☐ Investment by Overseas Organization ☐ Other please specify _____
34. Nature of Business	**Steps taken to employ Jamaican National**
35. Qualifications Necessary for Job (Details on Attachment)	43. Contacted Employment Service Public ☐ Private ☐ None ☐
36. Job Title and Duties to be Performed (Details on Attachment)	44. Internal Recruitment Yes ☐ No ☐ 45. By advertisement (Attach Copy) Locally ☐ Overseas ☐ 46. Other
37. Email address	47. If no step was taken please state reason (Details on Attachment)
48. Gross Salary offered Per Annum $.....	Kindly indicate in Jamaican currency for questions 48 & 49 49. Perquisites (Allowances) per Annum House $ ..... Car $..... Entertainment &..... Other $.....

50. STAFF COMPOSITION	CITIZEN-SHIP	PROFESSIONAL	CLERKS/ SERVICE WORKER	SKILLED WORKERS	PLANT & MACHINE OPERATORS	ELEMEN-TARY OCCUPA-TIONS	TOTAL
	JAMAICAN						
	CARICOM						
	COMMON-WEALTH						
	FORIEGN						

51.
Details of programme (if any) instituted by Employer to train citizens of Jamaica to fill posts now held by persons who are not citizens of Jamaica (Full explanatory memorandum to be attached).

I certify to the best of my knowledge and belief, that the above information is correct and accept the responsibiltiy for the support and repatriation expenses of the applicant and his family should the need arise.

_____ YYYY/MM/DD
Date

_____
Employer's/Sponsor's Signature

* Blank *

RECEIPT NUMBER

[ ]

Δ (Blank)

THE NURSING COUNCIL

NURSES AND MIDWIVES ACT 1964

APPLICATION BY PERSONS TRAINED OUTSIDE JAMAICA FOR ADMISSION TO THE GENERAL/MENTAL REGISTER

TO: The Nursing Council

1. Full Name: I, Lastname, firstname
   (SURNAME) (CHRISTIAN) (OTHER)
2. State here whether single or married, or widow, if married or widow, give maiden name and furnish certificate of marriage..... marital status
3. Date of birth.. month, day, year 4. Place of birth city, State, USA
5. Nationality.... American
6. Present Postal Address.... mailing address
7. Permanent postal Address .....
8. Name of Training School.... name of college/university
9. Address of Training School.... address of above
10. Period of training from.... month, year ..... to ..... month, year
    (Please give exact dates)

hereby request the Council to enter my name upon the part of the Register for General/Mental nurses maintained by the Council

★ I forward herewith the fee of $_____ and I promise in the event of my being so registered, and in consideration thereof, to be bound by, and to conform in all respects to, the Regulations for the time being in force.

I forward herewith my Certificate of Registration to the Register of ..... Nursing .....

.....

.....

Signature of applicant..... Sign here .....

Signature of witness.....

Address of witness.....

Date.....

If the application is not accepted the fee of $ will be returned to the applicant.

Form to be returned to THE REGISTRAR,
The Nursing Council,
25 Dominica Drive, Kingston 5

FOR OFFICE USE ONLY

[ ]

★ ACE pays all medical fees. This is included in the cost of your trip