

SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration:

NURSES

First Time

- Professional Registration for Short-Term Volunteer Form
 - Registrar section: “Nursing Council of Jamaica”
 - Your name, profession, dates of trip, working in “St. Mary rural clinics”
 - Local contact person or sponsor: “Dr. Tamara Henry, MD; Director of Health, St. Mary”
- Blue Form
 - Fill out as instructed
- Work Permit Exemption Application Form
 - Check the exemption box, complete items 1-8
 - Item 9 is your social security number
 - Complete items 10-19 (*extra requirements as of December 2018*)
 - Sign item 29
- Short Term Medical Trip Volunteer Form
- Curriculum Vitae (Resume)
- Certified copy of Birth Certificate*
- Certified copy Marriage Certificate (if applicable)*
- Certified copy of Certificate/Diploma from School of Nursing (degree you received your RN)*
- Certified Copy of Current License*
- 2 written references from Nursing Supervisors
- 2 passport-sized photographs

Returning Nurses and Jamaican Trained Nurses

- Short Term Medical Trip Volunteer Form
- Updated Curriculum Vitae (Resume)
- Certified Copy of Current License*
- Two written references from Nursing Supervisors
- Work Permit Exemption Application Form
- 1 passport-sized photograph

Students

- Short Term Medical Trip Volunteer Form
- Work Permit Exemption Application Form
- 2 passport-sized photographs
- A letter from the University verifying status of student(s)

* 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 TERM VOLUNTEERS

All Doctors, Dentists, Pharmacists, Nurses, Dietitians, Radiographers, Optometrists, Medical Technologists, Speech, Occupational and Physical Therapists must be registered with their respective Councils before practicing their professions in Jamaica, even if for a day. Also needing registration are Dental Hygienists and Technicians.

Medical Council

37 Windsor Avenue
Kingston 10
Tel: 978-8538

Dental Council

50 Half Way Tree Road
Kingston 5
Tel: 317-8643

Nursing Council

50 Half Way Tree Road
Kingston 5
Tel: 929-5118

Council of Professions Supplement to Medicine

50 Half Way Tree Road
Kingston 5
Tel: 754-8341

Pharmacy Council

91 Dumbarton Avenue
Kingston 10
Tel: 926-2637

Jamaica Optometric Association

York Plaza
1 ½ Hagley Park Road, Kingston 10
Tel: 929-8656

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 at the Ministry of Health. The whole process will be facilitated if the form is completely filled out and signed (by applicant, team sponsor, local and head office authorities) and sent with credentials and application forms to the respective Council as above.

A registration or processing fee is charged.

The Local Health Authority is the Medical Officer (Health).

SHORT TERM VOLUNTEER

Applicant's Address

Date: _____

REGISTRAR

_____ COUNCIL OF JAMAICA

I _____ apply for a special registration

As a _____ in order to volunteer my service
Profession

For the period _____ at _____
Dates (Specific) Facility/Location

In the (civil) Parish of _____

My Local Contact Person is:

Name: Dr. Tamara Henry, MD; Director of Health, St. Mary
Address: Port Maria Hospital, Port Maria PO, St. Mary, Jamaica, Wi
Telephone: (876) 994-2358

Sponsor's Signature

I recommend the above

Signature Position (Local Health Authority) Date

Signature Position (National Health Authority) Date

RECEIPT NUMBER

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,
(SURNAME) (CHRISTIAN) (OTHER)
2. State here whether single or married, or widow, if married or widow, give maiden name and furnish certificate of marriage.....
3. Date of birth..... 4. Place of birth.....
5. Nationality.....
6. Present Postal Address.....
7. Permanent postal Address
8. Name of Training School.....
9. Address of Training School.....
10. Period of training from..... to.....
(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

.....
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Signature of applicant.....

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



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	
2. Address (overseas, except in the case of renewal)		3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Date of Birth YYYY/MM/DD		5. Country & Place of Birth	
6. Nationality		7. Number Of Children/ Dependents		8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated			
9. TRN		10. Occupation		11. Period for which Permit/Exemption is required YYYY/MM/DD From _____ To _____			
12. Passport Number		13. Passport Expiry Date YYYY/MM/DD		14. Type of Passport (Country Issued)			
15. Qualification – Academic or Professional (Attach Documentary Evidence)				Details on previous (Last) Employer in Jamaica			
				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	
29. I certify to the best of my knowledge and belief, that the above information is correct							
_____ YYYY/MM/DD Date				_____ Applicant's Signature			

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 Registration Yes No	41. Date of registered? YYYY/MM/DD
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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 _____
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34. Nature of Business	Steps taken to employ Jamaican National
35. Qualifications Necessary for Job (Details on Attachment)	43. Contacted Employment Service Public <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/>

36. Job Title and Duties to be Performed (Details on Attachment)	44. Internal Recruitment Yes <input type="checkbox"/> No <input type="checkbox"/>
	45. By advertisement (Attach Copy) Locally <input type="checkbox"/> Overseas <input type="checkbox"/>
	46. Other

37. Email address	47. If no step was taken please state reason (Details on Attachment)
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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	CITIZENSHIP	PROFESSIONAL	CLERKS/SERVICE WORKER	SKILLED WORKERS	PLANT & MACHINE OPERATORS	ELEMEN-TARY OCCUPA-TIONS	TOTAL
	JAMAICAN						
	CARICOM						
	COMMONWEALTH						
	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 responsibility 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

SHORT-TERM MEDICAL TRIP VOLUNTEER FORM

Document required for registration with Ministry of Health

ACE Medical Mission Trip Form

Trip Leader's Name _____

Dates of Trip from _____ to _____

Full name (as it appears on passport): _____

Birth Date: _____ E-Mail Address: _____

Home Phone: (____) _____ Cell/Alternative Phone (____) _____

Address: _____

Medical field & area of practice (if applicable): _____

Passport # and expiration date: _____

I, _____, fully agree and understand that while on the above-mentioned medical trip, am under the leadership of the above-mentioned trip leader Doctor(s). I am working under their name(s), and vow to respect their leadership while I am in Jamaica.

Signature: _____

Date: _____