

SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration:

MEDICAL DOCTORS and other medical professionals

(Dietitians, Pharmacists, Radiographers, Optometrists, Medical Technologists,
Speech/Occupational/Physical Therapists)

First Time

- Professional Registration for Short-Term Volunteer Forms
 - Registrar section: “Medical 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”
- Form A – The Medical Act
 - 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
- Certified copy of Basic Degree Certificate – the one that says “Doctor of Medicine”*
- Certified copy of Current License*
- Names and Addresses of 2 Medical References
- 2 passport-sized photographs

If doctor was trained at an Offshore Medical School and has a Board Certificate, he/she needs to submit this.

Returning

- Professional Registration for Short-Term Volunteer Form (see instructions above)
- Form A – The Medical Act (see instructions above)
- Certified copy of Current License*
- Work Permit Exemption Application Form (see instructions above)
- 1 passport-sized photograph

Students

- Short Term 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

Your Name

Your Address

Applicant’s Address

Date: today’s date

REGISTRAR

Medical COUNCIL OF JAMAICA

I Your name apply for a special registration

As a Doctor in order to volunteer my service
Profession

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

(leave blank)

Sponsor’s Signature

I recommend the above

(leave blank)

Signature

Position (Local Health Authority)

Date

(leave blank)

Signature

Position (National Health Authority)

Date



MINISTRY OF LABOUR AND SOCIAL SECURITY
WORK PERMIT/EXEMPTION APPLICATION FORM

Be sure to click EXEMPTION

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 John	Last Name Doe	Middle Initial A	Alias
2. Address (overseas, except in the case of renewal) Home Address City, State ZIP	3. Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth YYYY/MM/DD 1972/03/26	5. Country & Place of Birth USA, City, State
6. Nationality American	7. Number Of Children/Dependents	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married <input type="checkbox"/> Separated	
9. TRN Social Security Number	10. Occupation Doctor	11. Period for which Permit/Exemption is required YYYY/MM/DD (leave blank) From _____ To _____	
12. Passport Number 123456789	13. Passport Expiry Date YYYY/MM/DD 2029/05/20	14. Type of Passport (Country Issued) USA	
15. Qualification – Academic or Professional (Attach Documentary Evidence) (leave blank)		Details on previous (Last) Employer in Jamaica	
		20. Name of Employer (leave blank)	
		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			
Date here - Year/Month/Day _____ YYYY/MM/DD		Sign here _____	
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	
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 <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)			
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	ELEMENTARY OCCUPATIONS	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.							
(leave blank) _____ YYYY/MM/DD				(leave blank) _____			
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 Dr. Mike Smith

Dates of Trip from May 2, 2023 to May 9, 2023

Full name (as it appears on passport): Your Name

Birth Date: March 26, 1972 E-Mail Address: YourEmail@xyz.com

Home Phone (if applicable): (____) _____ Cell/Alternative Phone (987) 654-3210

Address: Home Address

Medical field & area of practice (if applicable): Doctor, Internal Medicine

Passport # and expiration date: 123456789 5/20/29

I, Your Name, 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: Sign Here Date: Today's Date