SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration:

DENTISTS/DENTAL HYGIENISTS

ALL VOLUNTEERS
even if you've been to ACE within the last six months

(hard copies to be sent via FedEx 9 weeks prior to trip; address TBA)

- ☐ Professional Registration for Short Term Volunteer Form
  - Registrar section: "Medical Council of Jamaica"
  - Your name, profession, dates of trip, working in "St. Mary rural clinics"
  - Local contact person or sponsor: "Tamara Henry, MD; Director of Health, St. Mary
- ☐ Form A - Dental Act
- ☐ Work Permit Exemption Application Form
  - Complete items 1-8; check the exemption box
  - 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
- ☐ *Certified Degree Certificate *(Doctor of Dental Surgery or Hygienist degree)*
- ☐ *Certified Copy of Current License
- ☐ 3 professional recommendation letters
- ☐ 2 passport-sized photographs

MEDICAL 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)

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* 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

Dentists

FORM A (Regulation 5)

THE DENTAL ACT

APPLICATION FOR REGISTRATION AS A DENTIST

To the Dental Council of Jamaica

Name of Applicant .....
(Surname first, block letters)

Address (1) .....

Date of Birth..... Place of Birth.....

Nationality.....

Intended place of practice or employment.....

Qualifications:

Degree or Diploma.....Date granted (2) .....

Institution .....

Address.....

Postgraduate qualification.....Date.....

COUNTRIES OR INSTITUTIONS (in which you have practised since qualifying)	DATE FROM	TO

In what countries, states or provinces are you now registered or entitled to practice as a Dentist? **(3)**

.....

.....

Has your registration or entitlement to practice as a Dentist ever been cancelled or suspended?

.....

If so, for what reason, and on what date? .....

.....

Names and addresses of three character referees:

1. .....
2. .....
3. .....

I enclose:

(a) Certified (notarized) copies of diploma or degree and of current registration (if applicable); certified translation must accompany all credentials not in English .

(b) Applicable fee, (4).

(c) 2" x 2" passport type photograph,

I hereby apply to be registered as a Dentist and declare that I am the person named in the enclosed diplomas or certificates and that the above information is true and correct.

.....
Signature of Applicant

.....
Date

Form A - 2

(To be completed by a Dentist or Medical Practitioner registered in Jamaica or by a person of standing in the country of residence of the applicant who has known the applicant for at least a year.)

I .....of.....
(full name, block letters)

certify that I have been acquainted with the applicant for..... ..... years and that he/she is of good character.

Date..... Signed.....

Address.....

.....

.....

Qualification.....

.....

Notes:

(1) The Registrar must be notified of any subsequent change of address.

(2) Recent graduates must request the Dean of their institution to write directly to the Council to assure the Council that the applicant is a **bona fide** graduate.

(3) All other applicants must request their current registering body to write directly to the Council, stating the applicant is a dentist in good standing. This requirement need not be met by those seeking temporary registration.

(4) Examination Fee: $100 Registration/Application Fee: $200
(Temporary Registration Fee: $100)

To be completed by the Registrar

Type registration: Full .....Temporary.....

Date registered or application refused..... ....

Registration number, if full registration.....

Date and number of **Gazette** notice in which registration published..... .....

.....

Reason for refusal, if refused.....

.....

.....
Signature of Registrar

.....
Name (Block Letters)

.....
Date

Submit to: REGISTRAR
DENTAL COUNCIL **OF JAMAICA.**

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 ☐ Male ☐ Female	4. Date of Birth YYYY/MM/DD	5. Country & Place of Birth
6. Nationality	7. Number Of Children/ Dependents	8. Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ 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
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	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 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

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: _____