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)

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 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
  - 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 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
- ☐ Short Term Medical Trip Volunteer Form
- ☐ PHARMACISTS: Complete Form B

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

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)

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

FORM B
THE PHARMACY ACT, 1966
(ACT 5 OF 1966)
APPLICATION FOR REGISTRATION AS A PHARMACIST

To The Pharmacy Council
91 Dumbarton Ave
Kingston 10

Name of Applicant……...
(In Block Letters)
Age of applicant……
(Photostat of certified copies of Birth Certificate should be attached)

Date of Application……..…… Telephone No.. …….....

Address…….

Email…….

Qualification of applicant…….....
……
…….
(Photostat of certified copies of Qualifications should be attached)

Three testimonials to be attached (Two from registered pharmacists and one other)
Registration fee of $ 50.00 (USD) or its Jamaican equivalent
Two (2) Passport size photographs (certified to be true copies by a Justice of the Peace)

……...
Signature of applicant

To be completed by the Registrar

Date registered/refused…….

Registration no…….

Date and No. of Gazette Notice in which registration published…….

Reason for refusal, if refused……...…….

……

…….……
Signature of Registrar

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

FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

To the Medical Council

Name of Applicant _____

Date of Applicant _____

Address of Applicant

_____

_____ Tel No. _____

Date of Birth of Applicant _____ Sex: M _____ F_____

Qualifications of Applicant _____

Where were Qualifications obtained?

_____

_____

_____

Signature of applicant

Note*

1. Full Registration – Original Degree Certificate
2. Certified Photostat or certified copies of academic certificates of diplomas;
3. Certificate of Registration or License;
4. Certificate of Good Standing with registering body or valid License;
5. Names and addresses of two (2) medical referees;
6. Passport size photograph.

TO BE COMPLETED BY THE REGISTRAR

Date of registration or refusal _____

Registration No. _____

Reason for refusal if refused _____

_____

_____

Signature of Registrar

N.B. Form may be copied, not typed over.
A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION.

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 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

FORM B
THE PHARMACY ACT, 1966
(ACT 5 OF 1966)
APPLICATION FOR REGISTRATION AS A PHARMACIST

To The Pharmacy Council
91 Dumbarton Ave
Kingston 10

Name of Applicant……..
(In Block Letters)
Age of applicant……
(Photostat of certified copies of Birth Certificate should be attached)

Date of Application…… Telephone No.. ……

Address……

Email……

Qualification of applicant……
……
……
(Photostat of certified copies of Qualifications should be attached)

Three testimonials to be attached (Two from registered pharmacists and one other)
Registration fee of $ 50.00 (USD) or its Jamaican equivalent
Two (2) Passport size photographs (certified to be true copies by a Justice of the Peace)

……..
Signature of applicant

To be completed by the Registrar

Date registered/refused……

Registration no……

Date and No. of Gazette Notice in which registration published……

Reason for refusal, if refused……

……

……
Signature of Registrar

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: _____