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

Your Name
Your Address
_____
Applicant's Address

Date: today's date

REGISTRAR

Dental COUNCIL OF JAMAICA

I Your name apply for a special registration

As a Dentist or Dental Hygienist 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

Dentists

FORM A (Regulation 5)

THE DENTAL ACT

APPLICATION FOR REGISTRATION AS A DENTIST

To the Dental Council of Jamaica

Name of Applicant ..... LAST NAME, FIRST NAME (CAPITAL LETTERS)
(Surname first, block letters)

Address (1) ..... Home address

Date of Birth ..... DOB Place of Birth ..... City, State

Nationality ..... American

Intended place of practice or employment ..... St. Mary Rural Clinics

Qualifications:

Degree or Diploma ..... Decree received Date granted (2) ..... Date on Diploma

Institution ..... Name of College/University

Address ..... Address of College/University

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. ..... Name, address
2. ..... Name, address
3. ..... Name, address

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). Fees are collected by ACE and forwarded on to the appropriate entity

(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.

Sign here

.....
Signature of Applicant

Date here

.....
Date

Form A - 2

(leave this page blank)

(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.**

SAMPLE

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	Last Name	Middle Initial	Alias
John	Doe	A	

2. Address (overseas, except in the case of renewal)	3. Gender	4. Date of Birth YYYY/MM/DD	5. Country & Place of Birth
Home Address City, State ZIP	☒ Male ☐ Female	1972/03/26	USA, City, State

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

9. TRN	10. Occupation	11. Period for which Permit/Exemption is required YYYY/MM/DD
Social Security Number	Dentist	(leave blank) From_____ To_____

12. Passport Number	13. Passport Expiry Date YYYY/MM/DD	14. Type of Passport (Country Issued)
123456789	2029/05/20	USA

15. Qualification – Academic or Professional (Attach Documentary Evidence)	**Details on previous (Last) Employer in Jamaica**
(leave blank)	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
Date

Sign here _____
Applicant's Signature

SAMPLE

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)

(leave blank)

31b. Mailing Address (if different from above)

40. Is your Company Registration
Yes No

41. Date of registered?
YYYY/MM/DD

42. The request for Work Permit/Exemption is in relation to:
Bi/Multilateral Agreement
Investment by Overseas Organization
Other please specify _____

32. Telephone Number

33. Fax number

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.

(leave blank)
_____YYYY/MM/DD
Date

(leave blank)
_____
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): Dentist

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