# SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

**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

SAMPLE

# 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 |

SAMPLE

FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

To the Medical Council

Name of Applicant _____ Your Name _____

Date of Applicant _____ Today's Date _____

Address of Applicant

Home Address

_____ Tel No. _____ Phone Number _____

Date of Birth of Applicant _____ DOB _____ Sex: M _____ F _____ Check one

Qualifications of Applicant _____ Degrees and Certifications _____

Where were Qualifications obtained?

_____

_____

_____ Sign here _____

Signature of applicant

Note* Certified by a Notary Public; attach these items

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 references;
6. Passport size photograph.

TO BE COMPLETED BY THE REGISTRAR (leave everything below blank)

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.

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<br>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 | Doctor | (leave blank)<br>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

For Pharmacists only!

**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

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**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 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