SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration:

NURSES

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: "Nursing 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"
- ☐ Blue Form
  - 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
- ☐ Curriculum Vitae (Resume)
- ☐ Certified copy of Birth Certificate*
- ☐ Certified copy Marriage Certificate (if applicable)*
- ☐ Certified copy of Certificate/Diploma from School of Nursing *(degree you received your RN)**
- ☐ Certified Copy of Current License*
- ☐ 2 written references from Nursing Supervisors
- ☐ 2 passport-sized photographs

JAMAICAN TRAINED NURSES

- ☐ Short Term Medical Trip Volunteer Form
- ☐ Updated Curriculum Vitae (Resume)
- ☐ Certified Copy of Current License*
- ☐ Two written references from Nursing Supervisors
- ☐ Work Permit Exemption Application Form
- ☐ 1 passport-sized photograph

NURSING 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

Nursing 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 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

RECEIPT NUMBER

(leave blank)

THE NURSING COUNCIL

NURSES AND MIDWIVES ACT 1964

APPLICATION BY PERSONS TRAINED OUTSIDE JAMAICA FOR ADMISSION TO THE GENERAL/MENTAL REGISTER

TO: The Nursing Council. Last Name, First Name

1. Full Name: I, ... (SURNAME) (CHRISTIAN) (OTHER)
2. State here whether single or married, or widow, if married or widow, give maiden name and furnish certificate of marriage Marital Status
3. Date of birth Month, Day, Year 4. Place of birth Country, City, State
5. Nationality American
6. Present Postal Address Mailing address
7. Permanent postal Address .....
8. Name of Training School Name of College/University
9. Address of Training School Address of above
10. Period of training from Month, Year to Month, Year
(Please give exact dates)

ACE will collect fees with invoice and forward payment to the appropriate MOH entity

hereby request the Council to enter my name upon the part of the Register for General/Mental nurses maintained by the Council.

I forward herewith the fee of $_____ and I promise in the event of my being so registered, and in consideration thereof, to be bound by, and to conform in all respects to, the Regulations for the time being in force.

I forward herewith my Certificate of Registration to the Register of .....

.....

.....

Sign Here

Signature of applicant.....

Signature of witness.....

Address of witness.....

Date.....

If the application is not accepted the fee of $ will be returned to the applicant.

Form to be returned to THE REGISTRAR,
The Nursing Council,
25 Dominica Drive, Kingston 5

FOR OFFICE USE ONLY

SAMPLE

MINISTRY OF LABOUR AND SOCIAL SECURITY

WORK PERMIT/EXEMPTION APPLICATION FORM

Be sure to click EXEMPTIO

Foreign Nationals and Commonwealth Citizens Employment Act 1964)

Please indicate the type of application: ☐ **Work Permit** X ☐ **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	Nurse	(leave 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): Nurse, Emergency Room

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