NOVA SOUTHEASTERN UNIVERSITY
JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: ___________________________________________  DISCIPLINE:  Dentistry

Payment: Check# _____  Amount$ _____  Check# _____  Amount$ _____  Total ______

DENTISTS are REQUIRED to obtain the following:

☐ 1 copy of your passport
☐ 3 passport sized pictures (if you do not get them at a pharmacy, then you must print them in color & cut them to 2 inch x 2 inch or they will not be accepted - professional pictures please)
☐ 1 copy of current practice license
☐ FIRST TIME APPLICANT: YES _____  NO _____  (If YES, complete 1st time application information below)
   ☐ NOTARIZED copy of terminal degree (1st time applicants only)
   ☐ 2 letters of Professional Reference (1st time applicants only)

DENTISTS are REQUIRED to complete and submit the following items:

☐ Medical Mission Cover Sheet
  Tape 1 passport size picture (on all 4 sides at bottom of the application - this will not be done for you - no staples)
☐ Work Permit Exemption Application Form
  Complete sections #1-8, 10-14, & sign box #29
☐ Professional Registration for Short Term Volunteer
  Tape 1 passport size picture (on all 4 sides at bottom of the application - this will not be done for you - no staples)
☐ Form A - Application for Registration as a Dentist
  Tape 1 passport size picture on page 1 (on all 4 sides at top of the application - this will not be done for you - no staples)
☐ Copy of NSU Insurance card (front and back)
OR
☐ Complete the TravMed Abroad Travel Insurance Application
  You have two options for purchasing this plan (pay online and bring proof of payment or submit paper form). You must pay the $4/day (minimum 7 days) which is already included in the cost of the trip, or you can pay Medex Travel with a credit card online & deduct cost of insurance from the final cost of trip and submit copy of card.
  ***If you have private travel insurance submit proof of insurance; a copy of the card and policy of coverage for reparation and international coverage. If you cannot provide this, you must register and pay for Travel Insurance
☐ Liability Form
  Signed and witnessed by two people
☐ Expense Sheet
  Must be signed and submitted with application
NOVA SOUTHEASTERN UNIVERSITY
MEDICAL MISSION APPLICATION
JAMAICA

NAME: ______________________________________________________________

E-MAIL ______________________________________________________________

ADDRESS ___________________________ HOME PHONE _______________________

_________________________ OFFICE PHONE _____________________________

_________________________ FAX _________________________________________

STUDENT LEVEL: _____________ NSU ID (IF APPLICABLE) ________________

HEALTHCARE PROVIDERS ONLY (DO, MD, RM, PA, ETC...) ____________________

LICENSE #______________ STATE__________ SPECIALTY_________________

PREVIOUS MEDICAL MISSION EXPERIENCE? ____________________________
IF YES, STATE WHERE_____________________________________________

SHIRT SIZE: _____M _____L _____XL _____XXL _____OTHER

EMERGENCY CONTACT INFORMATION

NAME ________________________________________________________________

ADDRESS ___________________________________________________________

__________________________________________________________

PHONE # ___________________________________________________________

DO YOU HAVE ANY HEALTH PROBLEMS THAT MAY PROHIBIT YOUR FULL
PARTICIPATION FROM THIS MISSION? PLEASE LIST BELOW.

_____________________________________________________________________

PICTURE HERE
**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**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. First Name</td>
<td>Last Name</td>
<td>Middle Initial</td>
<td>Alias</td>
<td></td>
</tr>
<tr>
<td>2. Address (overseas, except in the case of renewal)</td>
<td>3. Gender</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>4. Date of Birth</td>
<td>YYYY/MM/DD</td>
<td>5. Country &amp; Place of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Married</td>
<td>Separated</td>
<td></td>
</tr>
<tr>
<td>9. TRN</td>
<td>10. Occupation</td>
<td>11. Period for which Permit/Exemption is required YYYY/MM/DD</td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>12. Passport Number</td>
<td>13. Passport Expiry Date YYYY/MM/DD</td>
<td>14. Type of Passport (Country Issued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Details on previous (Last) Employer in Jamaica</td>
<td>23. Applicant’s Work Permit Number</td>
<td>24. Expiry Date YYYY/MM/DD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Name of Employer</td>
<td>26. Address of Employer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Work Permit Number</td>
<td>28. Expiry Date YYYY/MM/DD</td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>30. Business Name/Name of Employer/Sponsor</th>
<th>38. TRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>31a. Business Address (Post Office Box # not acceptable)</td>
<td>39. Tax Compliance Certificate (TCC)</td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
</tr>
<tr>
<td>Parish</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31b. Mailing Address (if different from above)</th>
<th>40. Is your Company registered?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32. Telephone Number</th>
<th>33. Fax number</th>
<th>41. Date of Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YYYY/MM/DD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>34. Nature of Business</th>
<th>Steps taken to employ Jamaican National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>43. Contacted Employment Service</td>
</tr>
<tr>
<td></td>
<td>Public [ ] Private [ ] None [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>35. Qualifications Necessary for Job (Details on Attachment)</th>
<th>44. Internal Recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes [ ] No [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>36. Job Title and Duties to be Performed (Details on Attachment)</th>
<th>45. By advertisement (Attach Copy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Locally [ ] Overseas [ ]</td>
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<table>
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<tr>
<th>37. Email address</th>
<th>46. Other</th>
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<tr>
<th>47. If no step was taken please state reason (Details on Attachment)</th>
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</table>

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<thead>
<tr>
<th>48. Gross Salary offered Per Annum</th>
<th>49. Perquisites (Allowances) per Annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$……………………………………………</td>
<td>House $ ……………… Car $…………………</td>
</tr>
<tr>
<td></td>
<td>Entertainment &amp;…………….. Other $………………</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>50. STAFF COMPOSITION</th>
<th>CITIZENSHIP</th>
<th>PROFESSIONAL</th>
<th>CLERKS/ SERVICE WORKER</th>
<th>SKILLED WORKERS</th>
<th>PLANT &amp; MACHINE OPERATORS</th>
<th>ELEMEN-TARY OCCUPA-TIONS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAMAICAN</td>
<td></td>
<td></td>
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<tr>
<td>CARICOM</td>
<td></td>
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<tr>
<td>COMMON-WEALTH</td>
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<tr>
<td>FORIEGN</td>
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</table>

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<thead>
<tr>
<th>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).</th>
</tr>
</thead>
</table>

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
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
50 Half Way Tree Road
Kingston 5
Tel: 754-8341

Pharmacy Council
91 Dumbarton Avenue
Kingston 10
Tel: 926-2637

Jamaica Optometric Association
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: __________________________
Address: _______________________
Telephone: ______________________

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 .................................................................
(Block letters)

Date of Application ..............................................................

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 certificate of diploma
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 refer
6) Passport size photograph

TO BE COMPLETED BY THE REGISTRAR

Date of registration or refusal....................................................

Registration No.................................................................

Reasons for refusal if refused..................................................

.................................................................

.................................................................

.................................

Signature of Registrar

N.B. forms may be copied not typed over.

A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION
TravMed Abroad Enrollment Form

Mail application to: MEDEX Insurance Services, Inc. | P.O. Box 19056 Baltimore, Maryland 21284

Please call 800-732-5309 between 8:00 A.M - 5:00 P.M. EST Monday - Friday for telephone assistance. You may fax your enrollment to us at 410-308-7905.

Applicant Information

NAME(S) OF APPLICANT(S): DATE OF BIRTH
1) _______________________________          __________________
2) _______________________________          __________________
3)___________________________________         __________________

ADDRESS:
_____________________________________________________________________
Street Address
_____________________________________________________________________
City   State                                                   Zip

HOME PHONE: ________________________________________________________

WORK PHONE: ________________________________________________________

FAX NUMBER:

GROUP NAME: ________________________________________________________
(if applicable)

ARE YOU A PERMANENT RESIDENT OF THE U.S.?          YES  /  NO

LIST ALL MEDICAL CONDITIONS:
_____________________________________________________________________
_____________________________________________________________________

EMERGENCY CONTACT: ________________________________________________
EMERGENCY CONTACT PHONE: _________________________________________

PRIMARY OR OTHER INSURANCE PLAN:
NAME:________________________________________________________________

POLICY NUMBER: _____________________________________________________

PHONE NUMBER: _____________________________________________________

Declaration of Applicant

I hereby apply to purchase the insurance and agree that this declaration and the information given herein shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

Signature ___________________________________________            Date ___________

Dates of Coverage

FROM: ______________THROUGH: _________________    =     _____________
# of days of coverage
COUNTRIES VISITING: ________________________________________________________

Premium Calculation

I.  PER TRIP ENROLLMENT
7 day minimum, 90 day maximum per trip.

$4.00* X _______ = $ ________ X ________ = $ ________
# of days of travel # of persons

* $5.75 for ages 71-80, $8.00 for ages 81-85

II.  ANNUAL FREQUENT TRAVELER
No one trip can be more than 30 consecutive days. Please call for quote if average number of trips per year exceeds 5.

$200* X ___________ = $ __________
# of persons

* $250 for ages 71-80

OPTIONAL BENEFITS
Optional coverage(s) can only be purchased in conjunction with Plan I.

TRIP CANCELLATION AND INTERRUPTION
Minimum coverage: $300 Maximum coverage: $5,000; Price: 6% (.06) of coverage requested; Must be purchased more than 10 days prior to departure.

$.06 X coverage requested = $ ________ X ________ = $ ________
 # of persons

LOST BAGGAGE
Maximum Coverage: $1,000; Limit per article: $250; Deductible: $100;
Price: $2.50 per person, per day that baggage is checked on common carrier.

$2.50 X _______ = $ ________ X ________ = $ ________
# of days on common carrier # of persons

TOTAL PREMIUM DUE: $ __________

Payment Information

Method of Payment (circle one):
American Express / VISA / MasterCard / Check enclosed
(payable to TravMed Abroad)

CARD NUMBER: ________________________________

EXPIRATION DATE: ________________________________

CARDHOLDER: _______________________________________

SIGNATURE: _______________________________________

REV 6/94
NSU-COM INTERNATIONAL MEDICAL OUTREACH
RELEASE OF LIABILITY AND ASSUMPTION OF RISKS

THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISKS (the “Release”) is executed by me, ___________________________ whose address is ___________________________ in favor of NOVA SOUTHEASTERN UNIVERSITY, INC., a Florida not for profit corporation (the “University”), whose address is 3301 College Avenue, Fort Lauderdale, Florida 33314.

1. PARTICIPATION IN THE TRIP. I desire to participate in a trip to ___________________________ (state/country) scheduled to occur from ________ (beginning date) through ________ (ending date) for the primary purposes of travel (reason) (the “Trip”). I acknowledge that I am not required as part of academic program or otherwise to participate in the Trip.

2. WAIVER OF UNIVERSITY LIABILITY FOR DANGERS AND RISKS. I understand that there are certain dangers, hazards, and risks inherent in international travel and the activities to be engaged in during this Trip to ___________________________ (state/country) which can cause personal injury, death and property damage. I further understand that the University cannot and does not assume responsibility for any such personal injury, death or property damage.

3. ASSUMPTION OF RISKS. Notwithstanding the dangers, hazards, and risks involved, and in consideration of being permitted to participate in the Trip:

   (i) I agree to assume all the risks surrounding my participation in the Trip and in the activities I undertake in connection therewith; and
   (ii) I release and forever discharge the University, its trustees, officers, agents, employees, and any students acting as employees (hereafter collectively call the “Releasees”), from any and all liability for any injury, damage, claim, demand, action, cost, and expense of any nature that I may at any time have or incur, arising out of or in any manner related to any loss, damage, injury, including but not limited to suffering and death, that may be sustained by me or by any property belonging to me, while in ___________________________ (state or country) or in transit to and from ___________________________ (state/country).

4. DISCLAIMER OF UNIVERSITY RESPONSIBILITY.
I understand and agree that the University is

   (i) not responsible or liable for any injury, damage, loss, accident or delay which may be caused by a defect in any vehicle or other mode of transportation, or the negligence or other wrongful act of any party engaged to provide services connected with the trip.
   (ii) not responsible or liable for any injury, damage, loss or expense due to sickness, weather, strikes, hostilities, wars, natural disasters, terrorism, or other such causes,
   (iii) not responsible or liable for disruption of travel arrangements, or any consequent additional expenses that me be incurred therefrom, and
   (iv) not responsible or liable for any loss, damage, or theft of my luggage or other personal belongings.

5. RESPONSIBILITY FOR MEDICAL NEEDS.
I represent to the University that I am aware of my personal medical needs and that there are no health-related reasons or problems which preclude or restrict my participation in the Trip. I acknowledge that the University has strongly recommended that I obtain insurance coverage valid in ___________________________ (state/country) to protect against the cost of hospitalization and physician care in the event of sickness, accident, injury and disability. I understand that I am solely responsible for obtaining such insurance and that I will have a copy of such insurance on my person while traveling. I further understand and agree that

   (i) the University is not responsible for attending to any of my medical or medication needs,
   (ii) I assume all risks and responsibility for my medical and medication needs, and
   (iii) if I am required to be hospitalized at any time during the Trip, the University does not assume any legal responsibility for payment of such costs.

6. EMERGENCY MEDICAL TREATMENT.
I understand that the Releasees do not have medical personnel available at any time during the Trip. I grant the Releasees permission to authorize emergency medical treatment, including surgery, and I agree that such action by the Releasees shall be subject to the terms of this Release. I understand and agree that Releasees assume no liability or responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.
7. LEGAL PROBLEMS.
I understand that if I have a legal problem in ____________ (state/country) during the Trip, I will attend to the matter personally with my own funds and that the University is not responsible for providing any assistance to me under such circumstances.

8. BINDING NATURE OF RELEASE.
It is my express intent that this Release shall bind the members of my family (including my spouse, if any) if I am alive, and my heirs, personal representatives, successors, and assigns if I am deceased.

9. INDEMNIFICATION. I agree to indemnify, defend and hold the Releasees harmless from any liability, claim, action, debt, damage, loss, cost and expense of every kind or nature asserted by any party against any Releasees or incurred by any Releasee and arising directly or indirectly from or in connection with my participation in the Trip or any of the activities I engage in during the Trip.

10. RESERVATION OF RIGHTS. I acknowledge that the University reserves the following rights that it may exercise in its sole discretion:
   (i) the right to cancel the Trip, and
   (ii) the right to make alterations, changes, and modifications in any part of the Trip itinerary and the activities in connection therewith.

11. PASSPORT, VISA AND VACCINATIONS.
I understand that I am responsible for obtaining my own passport, visa, and public health vaccinations.

12. COMPLIANCE WITH LAWS. I agree to comply with all laws of ____________ (state/country) during the Trip.

13. DISCLOSURE. THE UNIVERSITY HAS INFORMED ME THAT BY SIGNING THIS DOCUMENT I RELEASE AND WAIVE CERTAIN LEGAL RIGHTS THAT I OTHERWISE MIGHT HAVE, AND THAT I SHOULD READ THE DOCUMENT CAREFULLY AND UNDERSTAND IT FULLY BEFORE SIGNING.

14. REPRESENTATIONS. I represent to the University that
   (i) I have read this Release and fully understand its contents and the effect of its terms and provisions,
   (ii) I sign the Release as my own free act and deed,
   (iii) with respect to the matters set forth in this Release, no oral representations, statements or inducements other than those expressly contained herein have been made to me by any of the Releasees, and
   (iv) I am over eighteen (18) years of age and fully competent to sign this Release, and
   (v) I execute this release for complete and adequate consideration, fully intending to be bound by the same.
   (vi)

15. GOVERNING LAW. I agree that this Release shall be construed in accordance with the laws of the State of Florida.

16. PARTIAL INVALIDITY. If any term or provision of this Release shall be held illegal, unenforceable, or in conflict with any law governing this Release, then I agree that the validity of all remaining terms and provisions shall not be affected thereby.

IN WITNESS WHEREOF, I have executed this Release of Liability and Assumptions of Risks this day _________ of ____________.

WITNESSES:                  PARTICIPANT:

___________________________  ___________________________
Signature                   Signature

___________________________  ___________________________
Printed Name                Printed Name

___________________________  ___________________________
Signature                   Signature

___________________________  ___________________________
Printed Name
EXHIBIT “A”

Problems and hazards that participants can experience:
1) Poor quality food or drinking water;
2) Food poisoning and/or skin rashes;
3) Circumstances of travel via plane, or local automobile;
4) Pick pockets, or theft at hotel or elsewhere during trip;
5) Sexual harassment and unwarranted sexual advances;
6) Natural events, e.g. earthquakes, tropical storms, volcanic activity, etc.
7) High altitude nausea, nose bleeds, headaches;
8) Drug availability and severe police/legal penalties;
9) Possible political instability;
10) Kidnapping, torture and death;
11) Guerrilla warfare;
12) Drug cartel violence;
13) Terrorist activity of any kind;
14) And any other unforeseen circumstances that can cause problems, permanent damage or even death.