NOVA SOUTHEASTERN UNIVERSITY
JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: ____________________________________________________  DISCIPLINE:  Optometry

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

OPTOMETRISTS 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)

OPTOMETRISTS 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)
☐ 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
# 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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</thead>
<tbody>
<tr>
<td>1.</td>
<td>First Name</td>
<td>Last Name</td>
<td>Middle Initial</td>
<td>Alias</td>
</tr>
<tr>
<td>2.</td>
<td>Address (overseas, except in the case of renewal)</td>
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<tr>
<td>3.</td>
<td>Gender</td>
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<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
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<tr>
<td>4.</td>
<td>Date of Birth</td>
<td>YYYY/MM/DD</td>
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<tr>
<td>5.</td>
<td>Country &amp; Place of Birth</td>
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<tr>
<td>6.</td>
<td>Nationality</td>
<td></td>
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<tr>
<td>7.</td>
<td>Number Of Children/ Dependents</td>
<td></td>
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<tr>
<td>8.</td>
<td>Marital Status</td>
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<tr>
<td></td>
<td>Single</td>
<td>Divorced</td>
<td>Widowed</td>
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<tr>
<td></td>
<td>Married</td>
<td>Separated</td>
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<tr>
<td>9.</td>
<td>TRN</td>
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<tr>
<td>10.</td>
<td>Occupation</td>
<td></td>
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<tr>
<td>11.</td>
<td>Period for which Permit/Exemption is required YYYY/MM/DD</td>
<td>From</td>
<td>To</td>
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<tr>
<td>12.</td>
<td>Passport Number</td>
<td></td>
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<tr>
<td>13.</td>
<td>Passport Expiry Date YYYY/MM/DD</td>
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<td>14.</td>
<td>Type of Passport (Country Issued)</td>
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<td>15.</td>
<td>Qualification – Academic or Professional (Attach Documentary Evidence)</td>
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<td>16.</td>
<td>Work Experience</td>
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<tr>
<td>17.</td>
<td>Skills of Applicant</td>
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<tr>
<td>18.</td>
<td>Husband/Wife’s Name</td>
<td></td>
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<tr>
<td>19.</td>
<td>Husband/Wife’s Nationality</td>
<td></td>
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<tr>
<td>20.</td>
<td>Name of Employer</td>
<td></td>
<td></td>
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<tr>
<td>21.</td>
<td>Address of Employer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>22.</td>
<td>Telephone Number</td>
<td></td>
<td></td>
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<tr>
<td>23.</td>
<td>Applicant’s Work Permit Number</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>24.</td>
<td>Expiry Date YYYY/MM/DD</td>
<td></td>
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<tr>
<td>25.</td>
<td>Name of Employer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26.</td>
<td>Address of Employer</td>
<td></td>
<td></td>
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<tr>
<td>27.</td>
<td>Work Permit Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>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

____________________________
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) Street</td>
<td>39. Tax Compliance Certificate (TCC)</td>
</tr>
<tr>
<td>City</td>
<td>Parish</td>
</tr>
<tr>
<td>31b. Mailing Address (if different from above) Street</td>
<td>40. Is your Company registered? Yes</td>
</tr>
<tr>
<td>City</td>
<td>41. Date of Registration YYYY/MM/DD</td>
</tr>
<tr>
<td>Parish</td>
<td></td>
</tr>
<tr>
<td>32. Telephone Number</td>
<td>33. Fax number</td>
</tr>
<tr>
<td>40. Is your Company registered? Yes</td>
<td>No</td>
</tr>
<tr>
<td>41. Date of Registration YYYY/MM/DD</td>
<td></td>
</tr>
<tr>
<td>42. The request for Work Permit/Exemption is in relation to: Bi/Multilateral Agreement</td>
<td>Investment by Overseas Organization</td>
</tr>
<tr>
<td>Other please specify _____________________</td>
<td></td>
</tr>
<tr>
<td>34. Nature of Business</td>
<td>35. Qualifications Necessary for Job (Details on Attachment)</td>
</tr>
<tr>
<td>36. Job Title and Duties to be Performed (Details on Attachment)</td>
<td></td>
</tr>
<tr>
<td>37. Email address</td>
<td>43. Contacted Employment Service Public</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>44. Internal Recruitment Yes</td>
<td>No</td>
</tr>
<tr>
<td>45. By advertisement (Attach Copy) Locally</td>
<td>Overseas</td>
</tr>
<tr>
<td>46. Other</td>
<td></td>
</tr>
<tr>
<td>47. If no step was taken please state reason (Details on Attachment)</td>
<td></td>
</tr>
<tr>
<td>48. Gross Salary offered Per Annum</td>
<td></td>
</tr>
<tr>
<td>Kindly indicate in Jamaican currency for questions 48 &amp; 49</td>
<td></td>
</tr>
<tr>
<td>$……………………………………………</td>
<td></td>
</tr>
<tr>
<td>49. Perquisites (Allowances) per Annum</td>
<td></td>
</tr>
<tr>
<td>House $ ……………… Car $……………………</td>
<td>Entertainment &amp;…………….. Other $………………..</td>
</tr>
<tr>
<td>50. STAFF COMPOSITION</td>
<td></td>
</tr>
<tr>
<td>CITIZENSHIP</td>
<td>PROFESSIONAL</td>
</tr>
<tr>
<td>JAMAICAN</td>
<td></td>
</tr>
<tr>
<td>CARICOM</td>
<td></td>
</tr>
<tr>
<td>COMMONWEALTH</td>
<td></td>
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<tr>
<td>FOREIGN</td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>______________ YYYY/MM/DD</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Employer’s/Sponsor’s Signature</td>
</tr>
</tbody>
</table>
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).

<table>
<thead>
<tr>
<th>Medical Council</th>
<th>Dental Council</th>
<th>Nursing Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 Windsor Avenue</td>
<td>50 Half Way Tree Road</td>
<td>50 Half Way Tree Road</td>
</tr>
<tr>
<td>Kingston 10</td>
<td>Kingston 5</td>
<td>Kingston 5</td>
</tr>
<tr>
<td>Tel: 978-8538</td>
<td>Tel: 317-8643</td>
<td>Tel: 929-5118</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Council of Professions</th>
<th>Pharmacy Council</th>
<th>Jamaica Optometric Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplement to Medicine</td>
<td>91 Dumbarton Avenue</td>
<td>York Plaza</td>
</tr>
<tr>
<td>50 Half Way Tree Road</td>
<td>Kingston 10</td>
<td>1 ½ Hagley Park Road, Kingston 10</td>
</tr>
<tr>
<td>Kingston 5</td>
<td>Tel: 926-2637</td>
<td>Tel: 929-8656</td>
</tr>
<tr>
<td>Tel: 754-8431</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

REGISTRAR

__________________________________________
COUNCIL OF JAMAICA

I __________________ apply for a special registration

As a __________________ in order to volunteer my service

Professional

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
## Applicant Information

<table>
<thead>
<tr>
<th>NAME(S) OF APPLICANT(S):</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ____________________</td>
<td>______________</td>
</tr>
<tr>
<td>2) ____________________</td>
<td>______________</td>
</tr>
<tr>
<td>3) ____________________</td>
<td>______________</td>
</tr>
</tbody>
</table>

ADDRESS:

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

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: _____________________________________________________

## Payment Information

**Method of Payment (circle one):**

American Express / VISA / MasterCard / Check enclosed

*(payable to TravMed Abroad)*

CARD NUMBER: _____________________________________________________

EXPIRATION DATE: _________________________________________________

CARDHOLDER: _____________________________________________________

SIGNATURE: _______________________________________________________

**Total Premium Due:** $ __________

## Dates of Coverage

FROM: ______________ THROUGH: _______________ = __________

total # of days of coverage

COUNTRIES VISITING:_________________________________________________

_____________________________________________________________________

## Premium Calculation

### I. PER TRIP ENROLLMENT

7 day minimum, 90 day maximum per trip.

\[
\text{Total Cost} = \text{Coverage Requested} \times \text{Number of Persons} \times 0.06
\]

* $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.

\[
\text{Total Cost} = \text{Coverage Requested} \times \text{Number of Persons} \times 0.06
\]

* $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% (0.06) of coverage requested;

Must be purchased more than 10 days prior to departure.

\[
\text{Total Cost} = \text{Coverage Requested} \times \text{Number of Persons} \times 0.06
\]

**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.

\[
\text{Total Cost} = \text{Number of Days} \times \text{Number of Persons} \times 2.50
\]

## 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 ____________________________

## TOTAL PREMIUM DUE: $ _________
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.

15. GOVERNING LAW. I agree that this Release shall be constructed 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: -----------------------------------------------------------------------------------------------

Signature
Printed Name

PARTICIPANT: -----------------------------------------------------------------------------------------------

Signature
Printed Name

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.