NOVA SOUTHEASTERN UNIVERSITY

JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: _____ DISCIPLINE: **Pharmacy**

Payment: Check#____ Amount$_____ Check#_____ Amount$_____ Total_____

PHARMCISTS 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
- ☐ 1 copy of birth certificate (notarized)
- ☐ 3 letters of Reference (2 - Professional and 1- character reference)
- ☐ **FIRST TIME APPLICANT: YES_____ NO___** (If **YES,** complete 1st time application information below)
  - ☐ NOTARIZED copy of terminal degree (1st time applicants only)
  - ☐ 1 copy of birth certificate (notarized)(1st time applicants only)

PHARMACISTS 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 B -Application for Registration as a Medical Practitioner

  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**

1. First Name | Last Name | Middle Initial | Alias

2. Address (overseas, except in the case of renewal)	3. Gender ☐ ☐ Male Female	4. Date of Birth YYYY/MM/DD	5. Country & Place of Birth
6. Nationality	7. Number Of Children/ Dependents	8. Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated	
9. TRN	10. Occupation	11. Period for which Permit/Exemption is required YYYY/MM/DD From_____ To_____	
12. Passport Number	13. Passport Expiry Date YYYY/MM/DD	14. Type of Passport (Country Issued)	

15. Qualification – Academic or Professional (Attach Documentary Evidence)	**Details on previous (Last) Employer in Jamaica**	
	20.Name of Employer	
	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

_____ YYYY/MM/DD _____

Date Applicant's Signature

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)

31b. Mailing Address (if different from above)

40. Is your Company registered?
Yes No

41. Date of Registration
YYYY/MM/DD

32. Telephone Number

33. Fax number

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

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	CITIZEN-SHIP	PROFESSIONAL	CLERKS/ SERVICE WORKER	SKILLED WORKERS	PLANT & MACHINE OPERATORS	ELEMEN-TARY OCCUPA-TIONS	TOTAL
	JAMAICAN						
	CARICOM						
	COMMON-WEALTH						
	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.

_____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 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

_____
_____
_____
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 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

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

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

REV 6/04

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.

$4.00* X _____ **= $** _____ **X** _____ **= $** _____
# of days of travel # of persons

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

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 _____ **= $** _____ **x** _____ **= $** _____
coverage requested total cost of coverage # 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

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*

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: _____

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 mu 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 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

_____
Signature

_____
Printed Name

PARTICIPANT:

_____
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.