# NOVA SOUTHEASTERN UNIVERSITY
# JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: ____________________________________________ DISCIPLINE: **Medicine**

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

**MEDICAL PROFESSIONALS 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)

**MEDICAL PROFESSIONALS 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 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<br>☐ ☐<br>Male Female | 4. Date of Birth<br><br>YYYY/MM/DD | 5. Country & Place of Birth |
|---|---|---|---|
| 6. Nationality | 7. Number Of Children/ Dependents | 8. Marital Status<br>☐ Single ☐ Divorced ☐ Widowed<br>☐ Married ☐ Separated | |
| 9. TRN | 10. Occupation | 11. Period for which Permit/Exemption is required YYYY/MM/DD<br><br>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

35. Qualifications Necessary for Job (Details on Attachment)

36. Job Title and Duties to be Performed (Details on Attachment)

37. Email address

**Steps taken to employ Jamaican National**

43. Contacted Employment Service
Public ☐ Private ☐ None ☐

44. Internal Recruitment Yes ☐ No ☐

45. By advertisement (Attach Copy) Locally ☐ Overseas ☐

46. Other

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).**

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**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

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Signature | Position (Local Health Authority) | Date

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Signature | Position (National Health Authority) | Date

**FORM A**

**THE MEDICAL ACT, 1976**

**APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER**

**<u>To the Medical Council</u>**

**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**

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**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 <u>not</u> 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

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.