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**

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<tbody>
<tr>
<td>1.</td>
<td>First Name</td>
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<td>Last Name</td>
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<td>Middle Initial</td>
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<td></td>
<td>Alias</td>
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<td>2.</td>
<td>Address (overseas, except in the case of renewal)</td>
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<td>3.</td>
<td>Gender</td>
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<td></td>
<td>Male</td>
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<td></td>
<td>Female</td>
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<td>4.</td>
<td>Date of Birth</td>
<td>YYYY/MM/DD</td>
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<td>5.</td>
<td>Country &amp; Place of Birth</td>
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<td>6.</td>
<td>Nationality</td>
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<td>7.</td>
<td>Number Of Children/Dependents</td>
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<td>8.</td>
<td>Marital Status</td>
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<td>Single</td>
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<td>Divorced</td>
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<td>Widowed</td>
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<td>Married</td>
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<td>Separated</td>
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<td>9.</td>
<td>TRN</td>
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<td>10.</td>
<td>Occupation</td>
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<td>11.</td>
<td>Period for which Permit/Exemption is required YYYY/MM/DD</td>
<td>From</td>
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<td>To</td>
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<td>12.</td>
<td>Passport Number</td>
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<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>
<td>Details on previous (Last) Employer in Jamaica</td>
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<td></td>
<td></td>
<td>20. Name of Employer</td>
<td></td>
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<td></td>
<td></td>
<td>21. Address of Employer</td>
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<td>16.</td>
<td>Work Experience</td>
<td></td>
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<tr>
<td>17.</td>
<td>Skills of Applicant</td>
<td>Details of Husband’s/Wife’s previous Employment in Jamaica</td>
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<td>25. Name of Employer</td>
<td></td>
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<td></td>
<td></td>
<td>26. Address of Employer</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>
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<td>27. Work Permit Number</td>
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<td>28. Expiry Date YYYY/MM/DD</td>
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<td>29.</td>
<td>I certify to the best of my knowledge and belief, that the above information is correct</td>
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<td></td>
<td>Date YYYY/MM/DD</td>
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<td></td>
<td>Applicant’s Signature</td>
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</tbody>
</table>
**PART 11**

**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

<table>
<thead>
<tr>
<th><strong>30. Business Name/Name of Employer/Sponsor</strong></th>
<th><strong>38. TRN</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>31a. Business Address (Post Office Box # not acceptable)</strong></th>
<th><strong>39. Tax Compliance Certificate (TCC)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th><strong>34. Nature of Business</strong></th>
<th><strong>Steps taken to employ Jamaican National</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>35. Qualifications Necessary for Job (Details on Attachment)</strong></th>
<th><strong>43. Contacted Employment Service</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Private</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>36. Job Title and Duties to be Performed (Details on Attachment)</strong></th>
<th><strong>44. Internal Recruitment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</table>

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<tr>
<th><strong>37. Email address</strong></th>
<th><strong>45. By advertisement (Attach Copy)</strong></th>
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<tr>
<td></td>
<td>Locally</td>
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<tr>
<th><strong>46. Other</strong></th>
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<tr>
<th><strong>47. If no step was taken please state reason (Details on Attachment)</strong></th>
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<tr>
<th><strong>48. Gross Salary offered Per Annum</strong></th>
<th><strong>49. Perquisites (Allowances) per Annum</strong></th>
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<tbody>
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</table>

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<thead>
<tr>
<th><strong>50. STAFF</strong></th>
<th><strong>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).</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPOSITION</td>
<td></td>
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<tr>
<td>CITIZENSHIP</td>
<td>PROFESSIONAL</td>
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<tr>
<td>JAMAICAN</td>
<td></td>
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<tr>
<td>CARICOM</td>
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<tr>
<td>COMMON-WEALTH</td>
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<tr>
<td>FOREIGN</td>
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<thead>
<tr>
<th><strong>52. Date</strong></th>
<th><strong>53. Employer’s/Sponsor’s Signature</strong></th>
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<tbody>
<tr>
<td>YYYY/MM/DD</td>
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</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).

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: 754-8431

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

Jamaica Optometric Association
York Plaza

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

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

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

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: _______________  =  ___________ total # of days of coverage

COUNTRIES VISITING:

---

### Premium Calculation

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

\[ \text{TRIP CANCELLATION AND INTERRUPTION} \]

Minimum coverage: $300  Maximum coverage: $5,000; Price: 6% (0.06) of coverage requested; Must be purchased more than 10 days prior to departure.

\[ \text{\$4.00} \times \frac{\text{# of days of travel}}{\text{# of persons}} = \text{\$} \]  
\[ \text{\$5.75 for ages 71-80, \$8.00 for ages 81-85} \]

**II. 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.

\[ \text{\$2.50} \times \frac{\text{# of days on common carrier}}{\text{# of persons}} = \text{\$} \]

**OPTIONAL BENEFITS**

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

---

### 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: ____________________

---

Note: 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.
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,
war, 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.

   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

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.