NOVA SOUTHEASTERN UNIVERSITY
JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: __________________________________________________  DISCIPLINE:  Dentistry

Payment: Check#  Amount$  Check#  Amount$  Total ________

DENTISTS are REQUIRED to obtain the following:

☐ 2 passport sized pictures (if you do not get them at a pharmacy, then you must print them in color & cut them to 2 inch x 2 inch or they will not be accepted - professional pictures please)
☐ 1 copy of current practice license

☐ FIRST TIME APPLICANT: YES_______  NO_______
   (If YES, complete 1st time application information below)
   ☐ NOTARIZED copy of terminal degree (1st time applicants only)
   ☐ 2 letters of Professional Reference (1st time applicants only)

DENTISTS are REQUIRED to complete and submit the following items:

☐ 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 (place in the blank space just below "applicants address")

☐ Form A - Application for Registration as a Dentist
   Tape 1 passport size picture on page 1 (place in blank space at the top of the form)
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: _____S _____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**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Address</strong> (overseas, except in the case of renewal)</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>4.</td>
<td><strong>Date of Birth</strong> YYY/MM/DD</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Country &amp; Place of Birth</strong></td>
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<tr>
<td>6.</td>
<td><strong>Nationality</strong></td>
</tr>
<tr>
<td>7.</td>
<td><strong>Number Of Children/Dependents</strong></td>
</tr>
<tr>
<td>8.</td>
<td><strong>Marital Status</strong></td>
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<tr>
<td></td>
<td>Married</td>
</tr>
<tr>
<td>9.</td>
<td><strong>TRN</strong></td>
</tr>
<tr>
<td>10.</td>
<td><strong>Occupation</strong></td>
</tr>
<tr>
<td>11.</td>
<td><strong>Period for which Permit/Exemption is required</strong> YYY/MM/DD</td>
</tr>
<tr>
<td></td>
<td>From_________ To_________</td>
</tr>
<tr>
<td>12.</td>
<td><strong>Passport Number</strong></td>
</tr>
<tr>
<td>13.</td>
<td><strong>Passport Expiry Date</strong> YYY/MM/DD</td>
</tr>
<tr>
<td>14.</td>
<td><strong>Type of Passport</strong> (Country Issued)</td>
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<tr>
<td>15.</td>
<td><strong>Qualification – Academic or Professional</strong> (Attach Documentary Evidence)</td>
</tr>
<tr>
<td></td>
<td><strong>Details on previous (Last) Employer in Jamaica</strong></td>
</tr>
<tr>
<td>20.</td>
<td><strong>Name of Employer</strong></td>
</tr>
<tr>
<td>21.</td>
<td><strong>Address of Employer</strong></td>
</tr>
<tr>
<td>16.</td>
<td><strong>Work Experience</strong></td>
</tr>
<tr>
<td>22.</td>
<td><strong>Telephone Number</strong></td>
</tr>
<tr>
<td>23.</td>
<td><strong>Applicant’s Work Permit Number</strong></td>
</tr>
<tr>
<td>24.</td>
<td><strong>Expiry Date</strong> YYY/MM/DD</td>
</tr>
<tr>
<td>17.</td>
<td><strong>Skills of Applicant</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Details of Husband/Wife’s previous Employment in Jamaica</strong></td>
</tr>
<tr>
<td>25.</td>
<td><strong>Name of Employer</strong></td>
</tr>
<tr>
<td>18.</td>
<td><strong>Husband/Wife’s Name</strong></td>
</tr>
<tr>
<td>26.</td>
<td><strong>Address of Employer</strong></td>
</tr>
<tr>
<td>19.</td>
<td><strong>Husband/Wife’s Nationality</strong></td>
</tr>
<tr>
<td>27.</td>
<td><strong>Work Permit Number</strong></td>
</tr>
<tr>
<td>28.</td>
<td><strong>Expiry Date</strong> YYY/MM/DD</td>
</tr>
<tr>
<td>29.</td>
<td><strong>I certify to the best of my knowledge and belief, that the above information is correct</strong></td>
</tr>
</tbody>
</table>

______________________ YYY/MM/DD  ____________________________

**Date**  **Applicant’s Signature**
## PART 11 TO BE COMPLETED BY PROSPECTIVE EMPLOYER

<table>
<thead>
<tr>
<th>30. Business Name/Name of Employer/Sponsor</th>
<th>38. TRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>31a. Business Address (Post Office Box # not acceptable) Street</td>
<td>39. Tax Compliance Certificate (TCC)</td>
</tr>
<tr>
<td>City</td>
<td>40. Is your Company registered? Yes No</td>
</tr>
<tr>
<td>Parish</td>
<td>41. Date of Registration YYYY/MM/DD</td>
</tr>
<tr>
<td>31b. Mailing Address (if different from above)</td>
<td></td>
</tr>
<tr>
<td>32. Telephone Number</td>
<td>33. Fax number</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>37. Email address</td>
</tr>
<tr>
<td>38. TRN</td>
<td>39. Tax Compliance Certificate (TCC)</td>
</tr>
<tr>
<td>40. Is your Company registered? Yes No</td>
<td>41. Date of Registration YYYY/MM/DD</td>
</tr>
<tr>
<td>42. The request for Work Permit/Exemption is in relation to: Bi/Multilateral Agreement Investment by Overseas Organization Other please specify</td>
<td></td>
</tr>
<tr>
<td>43. Contacted Employment Service Public Private None</td>
<td></td>
</tr>
<tr>
<td>44. Internal Recruitment Yes No</td>
<td>45. By advertisement (Attach Copy) Locally Overseas</td>
</tr>
<tr>
<td>46. Other</td>
<td>47. If no step was taken please state reason (Details on Attachment)</td>
</tr>
<tr>
<td>48. Gross Salary offered Per Annum $……………………………………………</td>
<td>49. Perquisites (Allowances) per Annum</td>
</tr>
<tr>
<td>50. STAFF COMPOSITION</td>
<td>Kindly indicate in Jamaican currency for questions 48 &amp; 49</td>
</tr>
<tr>
<td>CITIZENSHIP</td>
<td>House $ ……………… Car $……………………</td>
</tr>
<tr>
<td>PROFESSIONAL WORKER</td>
<td>Entertainment &amp;…………….. Other $………………..</td>
</tr>
<tr>
<td>CLERKS/ SERVICE WORKER</td>
<td></td>
</tr>
<tr>
<td>SKILLED WORKERS</td>
<td></td>
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<tr>
<td>PLANT &amp; MACHINE OPERATORS</td>
<td></td>
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<tr>
<td>ELEMEN- TARY OCCUPA- TIONS</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
<tr>
<td>JAMAICAN</td>
<td></td>
</tr>
<tr>
<td>CARICOM</td>
<td></td>
</tr>
<tr>
<td>COMMON-WEALTH</td>
<td></td>
</tr>
<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>
</tbody>
</table>

____________________________ 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  Dental Council  Nursing Council
37 Windsor Avenue  50 Half Way Tree Road  50 Half Way Tree Road
Kingston 10  Kingston 5  Kingston 5
Tel: 978-8538  Tel: 317-8643  Tel: 929-5118

Council of Professions  Pharmacy Council  Jamaica Optometric Association
Supplement to Medicine  91 Dumbarton Avenue  York Plaza
50 Half Way Tree Road  Kingston 10  1 ½ Hagley Park Road, Kingston 10
Kingston 5  Tel: 926-2637  Tel: 929-8656  Tel: 754-8341

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

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 DENTAL ACT
APPLICATION FOR REGISTRATION AS A DENTIST

To the Dental Council of Jamaica

Name of Applicant ................................................................. (Surname first, block letters)

Address (1) .................................................................................

Date of Birth ................................................................. Place of Birth .................................................................

Nationality ..............................................................................

Intended place of practice or employment .................................................................

Qualifications:

Degree or Diploma .................................................................Date granted (2) .................................................................

Institution ..............................................................................

Address ..............................................................................

Postgraduate qualification ..............................................................................Date .................................................................

COUNTRIES OR INSTITUTIONS (in which you have practised since qualifying) FROM DATE TO

In what countries, states or provinces are you now registered or entitled to practice as a Dentist? (3)

Has your registration or entitlement to practice as a Dentist ever been cancelled or suspended?

If so, for what reason, and on what date?

Names and addresses of three character referees:

1. ..............................................................................

2. ..............................................................................

3. ..............................................................................

I enclose:

(a) Certified (notarized) copies of diploma or degree and of current registration (if applicable); certified translation must accompany all credentials not in English.

(b) Applicable fee, (4).

(c) 2" × 2" passport type photograph,

I hereby apply to be registered as a Dentist and declare that I am the person named in the enclosed diplomas or certificates and that the above information is true and correct.

................................................................. Signature of Applicant

................................................................. Date
Form A - 2

(To be completed by a Dentist or Medical Practitioner registered in Jamaica or by a person of standing in the country of residence of the applicant who has known the applicant for at least a year.)

I .........................................................................................................................
(full name, block letters)
certify that I have been acquainted with the applicant for ................................... years and that he/she is of good character.

Date................................................... Signed.....................................................
Address........................................................................................................
...........................................................................................................
Qualification..............................................................................................
...........................................................................................................
...........................................................................................................

Notes:

(1) The Registrar must be notified of any subsequent change of address.

(2) Recent graduates must request the Dean of their institution to write directly to the Council to assure the Council that the applicant is a bonafide graduate.

(3) All other applicants must request their current registering body to write directly to the Council, stating the applicant is a dentist in good standing. This requirement need not be met by those seeking temporary registration.

(4) Examination Fee: $100 Registration/Application Fee: $200
(Temporary Registration Fee: $100)

To be completed by the Registrar

Type registration: Full ................................ Temporary ........................................
Date registered or application refused ...............................................................
Registration number, if full registration ..........................................................
Date and number of Gazette notice in which registration published ...............
...........................................................................................................
Reason for refusal, if refused ...........................................................................
...........................................................................................................

-----------------------------------------------------------
Signature of Registrar

-----------------------------------------------------------
Name (Block Letters)

-----------------------------------------------------------
Date

Submit to: REGISTRAR
DENTAL COUNCIL OF JAMAICA.
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 construed in accordance with the laws of the State of Florida.

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

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

WITNESSES:  PARTICIPANT:

________________________  __________________________
Signature                                      Signature

________________________  __________________________
Printed Name                                Printed Name

________________________
Signature

________________________
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.