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:

- ☐ 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
- ☐ 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:

- ☐ 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 B -Application for Registration as a Medical Practitioner

  Tape 1 passport size picture on page 1 (place in blank space at the top of the form)

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

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