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:

- ❑ 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)

MEDICAL PROFESSIONALS 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 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 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