NOVA SOUTHEASTERN UNIVERSITY

JAMAICA MEDICAL MISSION HEALTH PROFESSIONAL CHECKLIST

NAME: _____ DISCIPLINE: **Nursing**

Payment: Check#_____ Amount$_____ Check#_____ Amount$_____ Total_____

NURSES 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
- □ 1 copy of birth certificate (notarized)
- □ 2 letters of Reference (2 – Professional reference)
- □ Curriculum Vitae
- □ **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)
    - □ NOTARIZED copy of marriage certificate (if applicable) (1st time applicants only)

NURSES 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)
- □ The Nursing Council Form

  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)
- □ Proof of Travel Insurance

  ngcug uwdo v c eqr qh vtc gn puwtcpeg ectf y v qwt crrn ecv qp0 v u ocpfcvqt v cv g gt rctv e rcpv c g crrtqrt cvg puwtcpeg eq gtcig0 wdo v rtqqh qh puwtcpeg c eqr qh v g ectf fgoqpuvtcv pi eq gtcig vq penwfg .222.222 gf ecn q gtcig *pq fgfwev dng . y v gogtigpe g cewcv qp cpf tgrctcv qp0 * gg coc ec uu qp t r Igpgtcn phq ggv hqt puwtcpeg qrv qpu 0
- □ Liability Form

  Signed and witnessed by two people
- □ Expense Sheet

  Must be signed and submitted with application

GUIDELINES FOR SHORT-TERM VOLUNTEERS
DOCUMENTS REQUIRED FOR REGISTRATION

NURSES

First Time

- Short-Term Volunteer Form
- Nursing Council Form
- Curriculum Vitae (Resume)
- Certified copy of Birth Certificate
- Certified copy Marriage Certificate (if applicable)
- Certified copy of Certificate/Diploma from School of Nursing
- Certified Copy of Current Licence
- Two written reference letters
- Work Permit Exemption Application Form
- 2 passport-sized photographs

Returning

- Short-Term Volunteer Form
- Updated Curriculum Vitae (Resume)
- Certified Copy of Current Licence
- Two reference letters
- Work Permit Exemption Application Form
- 1 photograph

FEES

- Registration

  First Time - US$50.00 each
  Returning - US$30.00 each

- Work Permit Exemption

  All persons - JA$1,000.00 each

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: _____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

RECEIPT NUMBER

THE NURSING COUNCIL

NURSES AND MIDWIVES ACT 1964

APPLICATION BY PERSONS TRAINED OUTSIDE JAMAICA FOR ADMISSION TO THE GENERAL/MENTAL REGISTER

TO: The Nursing Council.

1. Full Name: I, ... (SURNAME) (CHRISTIAN) (OTHER)
2. State here whether single or married, or widow, if married or widow, give maiden name and furnish certificate of marriage.....
3. Date of birth..... 4. Place of birth.....
5. Nationality.....
6. Present Postal Address.....
7. Permanent postal Address .....
8. Name of Training School.....
9. Address of Training School.....
10. Period of training from.....to.....
(Please give exact dates)

hereby request the Council to enter my name upon the part of the Register for General/ Mental nurses maintained by the Council.

I forward herewith the fee of $_____ and I promise in the event of my being so registered, and in consideration thereof, to be bound by, and to conform in all respects to, the Regulations for the time being in force.

I forward herewith my Certificate of Registration to the Register of .....

.....

.....

Signature of applicant.....

Signature of witness.....

Address of witness.....

Date.....

If the application is not accepted the fee of $ will be returned to the applicant.

Form to be returned to THE REGISTRAR,
The Nursing Council,
25 Dominica Drive, Kingston 5

FOR OFFICE USE ONLY

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

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	**Steps taken to employ Jamaican National**
35. Qualifications Necessary for Job (Details on Attachment)	43. Contacted Employment Service Public ☐ Private ☐ None ☐
36. Job Title and Duties to be Performed (Details on Attachment)	44. Internal Recruitment Yes ☐ No ☐ 45. By advertisement (Attach Copy) Locally ☐ Overseas ☐ 46. Other
37. Email address	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).

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

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.