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:

- □ 3 passport sized pictures (if you do not get them at a pharmacy, then you must print them i n 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:

- □ 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")

- □ The Nursing Council Form

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

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

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

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