

SHORT-TERM MEDICAL VOLUNTEER GUIDELINES

Documents required for registration:

MEDICAL DOCTORS

First Time**

- **Professional Registration for Short-Term Volunteers Form:**
 - Registrar section: "Medical Council of Jamaica"
 - Your name, profession, dates of trip, working in "St. Mary rural clinics"
 - Local contact person or sponsor: "San San Win, MD; Director of Health, St. Mary"
- **Work Permit Exemption Application Form:**
 - Check the exemption box, complete items 1-8
 - Item 9 is your social security number
 - Complete items 10-14
 - Sign item 29
- **Form A – The Medical Act:**
 - Fill out as instructed
- **Certified copy of Basic Degree Certificate***
 - The one that says "Doctor of Medicine"
- **Certified copy of current License***
- **Certified copy of front page of passport***
- **Names and addresses of 2 Medical References**
- **2 passport-sized photographs**

***If doctor was trained at an offshore medical school and has a Board Certificate he/she also needs to submit this.*

Returning

- **Short-Term Volunteer Form (see instructions above)**
- **Work Permit Exemption Application Form (see instructions above)**
- **Form A – The Medical Act**
- **Certified copy of current License***
- **Certified copy of front page of passport* (if passport has been renewed)**
- **1 passport-sized photograph**

Medical Students

- **Short-Term Volunteer Form (see instructions above)**
- **Work Permit Exemption Application Form (see instructions above)**
- **2 passport-sized photographs**
- **A letter from the University verifying status of student(s)**
- **Certified copy of front page of passport***

* Certified copies are made by taking your original documents along with the copies to a notary and having them certify with their stamp

PROFESSIONAL REGISTRATION FOR SHORT TETRM VOLUNTEERS

All doctors dentists, pharmacists, nurses, dieticians, radiographers, medical technologists, speech, occupational and physical therapists must be registered with their respective Council before practicing their professions in Jamaica, even if only for a day. (Also needing registration are dental hygienists, technicians)

Medical Council
2-4 Kings Street
Kingston, Jamaica
Tel: (876) 922-3529/967-1549

Dental Council
41 Main Street
Mandeville, Jamaica
Tel; (876) 962-6488

**Council Professions
Supplementary to Medicine**
2-4 Kings Street
Kingston, Jamaica
Tel: (876) 922-3529/967-1549

Nursing Council
The Towers
25 Dominica Drive
Kingston 5, Jamaica
Tel: (876) 926-6042

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 of Ministry of Health. The whole process will be facilitated if the form below is filled out and signed (by applicant, of sponsor for him/her, local and head office authorities) and sent with credentials and application form to the respective Council as above.

A small 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 special registration
As a _____ in order to volunteer my service

Profession
For the period of _____ at _____
Dates (specific) Facility/Location

In the (civil) parish of _____

My local contact person is:

NAME: Dr. San San Win, MD; Director of Health, St. Mary
ADDRESS: Port Maria Hospital, Port Maria PO, St. Mary, Jamaica, WI
TEL: (876) 994-2358

Sponsor's Signature

I recommend the above

Signature Position Local Health Authority Date

Signature Position Head Office, Ministry of Health Date



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth YYYY/MM/DD	5. Country & Place of Birth
6. Nationality	7. Number Of Children/ Dependents	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> 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 <input type="checkbox"/> Investment by Overseas Organization <input type="checkbox"/> 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 <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/>			
36. Job Title and Duties to be Performed (Details on Attachment)				44. Internal Recruitment Yes <input type="checkbox"/> No <input type="checkbox"/>			
				45. By advertisement (Attach Copy) Locally <input type="checkbox"/> Overseas <input type="checkbox"/>			
				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 responsibility 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							

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 certificates of diplomas;
- 3) Certificate of Registration or Licence;
- 4) Certificate of Good Standing with registering body or valid Licence;
- 5) Names and address of two (2) medical referees;
- 6) Passport size photograph.

TO BE COMPLETED BY THE REGISTRAR

Date of registration or refusal _____

Registration No. _____

Reason for refusal if refused _____

Signature of Registrar

A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION