

THE DENTAL ACT
APPLICATION FOR REGISTRATION AS A DENTIST

To the Dental Council of Jamaica

Name of Applicant (Surname first, block letters)

Address (1)

Date of Birth Place of Birth

Nationality

Intended place of practice or employment

Qualifications:

Degree or Diploma Date granted (2)

Institution

Address

Postgraduate qualification Date

Table with 4 columns: COUNTRIES OR INSTITUTIONS (in which you have practised since qualifying), FROM, DATE, TO

In what countries, states or provinces are you now registered or entitled to practice as a Dentist? (3)

Has your registration or entitlement to practice as a Dentist ever been cancelled or suspended?

If so, for what reason, and on what date?

Names and addresses of three character referees:

- 1.
2.
3.

I enclose:

- (a) Certified (notarized) copies of diploma or degree and of current registration (if applicable); certified translation must accompany all credentials not in English.
(b) Applicable fee, (4).
(c) 2" x 2" passport type photograph,

I hereby apply to be registered as a Dentist and declare that I am the person named in the enclosed diplomas or certificates and that the above information is true and correct.

Signature of Applicant

Date

(To be completed by a Dentist or Medical Practitioner registered in Jamaica or by a person of standing in the country of residence of the applicant who has known the applicant for at least a year.)

I ..... of.....  
(full name, block letters)

certify that I have been acquainted with the applicant for..... years and that he/she is of good character.

Date..... Signed.....

Address.....

.....

.....

Qualification.....

.....

Notes:

- (1) The Registrar must be notified of any subsequent change of address.
- (2) Recent graduates must request the Dean of their institution to write directly to the Council to assure the Council that the applicant is a **bona fide** graduate.
- (3) All other applicants must request their current registering body to write directly to the Council, stating the applicant is a dentist in good standing. This requirement need not be met by those seeking temporary registration.
- (4) Examination Fee: \$100 Registration/Application Fee: \$200  
(Temporary Registration Fee: \$100)

To be completed by the Registrar

Type registration: Full .....Temporary.....

Date registered or application refused.....

Registration number, if full registration.....

Date and number of **Gazette** notice in which registration published.....

.....

Reason for refusal, if refused.....

.....

.....  
*Signature of Registrar*

.....  
*Name (Block Letters)*

.....  
*Date*

Submit to: REGISTRAR  
DENTAL COUNCIL OF JAMAICA.

FORM A

THE DENTAL ACT

APPLICATION FOR REGISTRATION AS A DENTAL PRACTITIONER

To the Dental Council

Name of Applicant \_\_\_\_\_

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 addresses of three (3) medical references;
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

N.B. Form may be copied, not typed over.

A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION.

MINISTRY OF HEALTH

PERSONNEL DIVISION  
2-4 KING STREET  
KINGSTON

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Ministry of Labour  
1f North Street  
Kingston

Attention: \_\_\_\_\_

RE: Work Permit Exemption for Short-Term Volunteer

Please grant an exemption from the Work Permit requirement to the following:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_

NATIONALITY \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ NO. OF CHILDREN \_\_\_\_\_

PROFESSION \_\_\_\_\_ QUALIFICATION \_\_\_\_\_

PERIOD OF VOLUNTEER SERVICE \_\_\_\_\_

LOCATION OF VOLUNTEER SERVICE \_\_\_\_\_

The ABOVE VOLUNTEER has been duly registered by his/her appropriate Council of Jamaica and has been given permission for the above period of service by this Ministry.

\_\_\_\_\_  
FOR: The Director of Personnel

Please attach one Passport Photograph.

**PROFESSIONAL REGISTRATION FOR SHORT TERM 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 King Street  
Kingston, Jamaica  
Tel: (876) 922-3116/967-1549

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

**Council Professions  
Supplementary to Medicine**  
2-4 King 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 at the 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 \_\_\_\_\_ at \_\_\_\_\_  
Dates(specific) Facility/Location

In the (civil) parish of \_\_\_\_\_

My local contact person or sponsor is:

**NAME** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_  
**TEL. NO** \_\_\_\_\_

\_\_\_\_\_  
**Sponsor's Signature**

**I recommend the above**

\_\_\_\_\_  
Signature Position Local Health Authority Date

\_\_\_\_\_  
Signature Position Head Office, Ministry of Health Date

\_\_\_\_\_

*\*Instructions for dental volunteer attachments to registration.  
Each dental professional must supply the following:*

1. Full Registration—Original Degree Certificate  
*(Not required for short term volunteer)*
2. Certified Photostat or certified copies of academic certificates of diplomas;  
**Two (2) notarized copies of his/her medical school diploma**
3. Certificate of Registration or Licence;  
**If applicable** *(Therapists, Homeopaths, Dental Hygienists, Etc.)*
4. Certificate of Good Standing with registering body or valid License;  
**Two (2) notarized photocopies of his/her dental licence** *(This is your wallet license)*
5. Names and addresses of three (3) medical references;  
**Three (3) medical references** *(see page one of application)*
6. Passport size photograph.  
**Two (2) notarized passport size photographs**