

THE PROFESSIONS SUPPLEMENTARY TO MEDICINE

APPLICATION FOR REGISTRATION AS PROFESSIONS SUPPLEMENTARY TO
MEDICINE

To the Professions Supplementary to Medicine 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 License;
4. Certificate of Good Standing with registering body or valid License;
5. Names and addresses of two (2) 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

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 Medical volunteer attachments to registration.
Each health 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 License;
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 physician's license *(This is your wallet license)*

5. Names and addresses of two (2) medical references;
Two (2) medical references

6. Passport size photograph.
Two (2) notarized passport size photographs