1 ~~Doctors~~ ALL providers

FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

To the Medical Council

Name of Applicant _____

Date of Applicant _____

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 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

N.B. Form may be copied, not typed over.
A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION.

(7) ALL Providers

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
2-4 king Street
Kingston, Jamaica
Tel: 922-3116

Dental Council
41 Main Street
Mandeville, Jamaica
Tel: 962-6488

Nursing Council
50 Half Way Tree Road
Kingston 5, Jamaica
Tel: 960-0823

Council Professions Supplement to Medicine
2-4King Street
Kingston, Jamaica
Tel: 922-3529

Pharmacy Council
91 Dumbarton Avenue
Kingston 10, Jamaica
Tel: **926-2637**

Jamaica Optometric Association
York Plaza, Shop 14
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 below 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 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 is:
Name: _____
Address: _____
_____
Tel: _____

_____
Sponsor's signature

I recommend the above

Signature	**Position (Local Health Authority)**	**Date**
Signature	**Position (Local Health Authority)**	**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 ☐ ☐ 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)

16. Work Experience

17. Skills of Applicant

18. Husband/Wife's Name

19. Husband/Wife's Nationality

Details on previous (Last) Employer in Jamaica

20. Name of Employer

21. Address of Employer

22. Telephone Number

23. Applicant's Work Permit Number

24. Expiry Date YYYY/MM/DD

Details of Husband's/Wife's previous Employment in Jamaica

25. Name of Employer

26. Address of Employer

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 II 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

35. Qualifications Necessary for Job (Details on Attachment)

36. Job Title and Duties to be Performed (Details on Attachment)

37. Email address

Steps taken to employ Jamaican National

43. Contacted Employment Service
Public ☐ Private ☐ None ☐

44. Internal Recruitment Yes ☐ No ☐

45. By advertisement (Attach Copy) Locally ☐
Overseas ☐

46. Other:

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 $.....

THIS IS A VOLUNTARY POSITION WITH NO FINANCIAL REIMBURSMENT

50. STAFF COMPOSITION	CITIZEN-SHIP	PROFESSIONAL	CLERKS/ SERVICE WORKER	SKILLED WORKERS	PLANT & MACHINE OPERATORS	ELEMEN-TARY OCCUPA-TIONS	TOTAL
	JAMAICAN						
	CARICOM						
	COMMON-WEALTH						
	FOREIGN						

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