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: Camille Wilson
Address: ________________
____
Tel: 876-489-7118

____
Sponsor's signature

I recommend the above

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

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