

## 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**  
37 Windsor Avenue  
Kingston 10  
Tel: 978-8538

**Dental Council**  
50 Half Way Tree Road  
Kingston 5  
Tel: 317-8643

**Nursing Council**  
50 Half Way Tree Road  
Kingston 5  
Tel: 929-5118

**Council of Professions  
Supplement to Medicine**  
50 Half Way Tree Road  
Kingston 5  
Tel: 754-8341

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

**Jamaica Optometric Association**  
York Plaza  
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 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 registration or processing fee is charged.*  
**The Local Health Authority is the Medical Officer (Health).**

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### SHORT TERM VOLUNTEER

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Applicant's Address**  
**Date:** \_\_\_\_\_

#### REGISTRAR

\_\_\_\_\_ COUNCIL OF JAMAICA

I \_\_\_\_\_ apply for a 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: \_\_\_\_\_  
Telephone: \_\_\_\_\_

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

I recommend the above

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

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Signature \_\_\_\_\_ Position (National Health Authority) \_\_\_\_\_ Date \_\_\_\_\_