DENTAL COUNCIL OF JAMAICA

50 HALF WAY TREE ROAD

KINGSTON 5

DENTAL VOLUNTEER APPLICATION FORM

APPLICANT INFORMATION

FULL NAME: DATE: _______________

SURNAME FIRST NAME M.I.

ADDRESS

STREET ADDRESS APARTMENT #

CITY STATE ZIP#:

APPLICANT SIGNATURE: ___________________________________ DATE: ___________________

PHONE NO.:______________________

EMAIL ADDRESS: _______________________________

NAME OF SPONSOR(S):

ADDRESS OF SPONSOR(S)/SPONSORING ORGANISATION(S):____________________________________

PLANNED OUTREACH ACTIVITY (IES)

START DATE: END DATE

KINDLY INDICATE WHICH CATEGORY OF VOLUNTEER

- DENTAL SURGEON ☐
- DENTAL THERAPIST ☐
- DENTAL HYGIENIST ☐
- DENTAL ASSISTANT ☐

LIABILITY INSURANCE COVERAGE

☐ I have malpractice insurance, which will cover services rendered during my stay in Jamaica.

☐ I will attach a copy of my liability insurance to application forms.

☐ I have no malpractice insurance.

License and Certification

State License or Certification #: ____________________

State License or Certification Expiration Date: ____________________

DEA #: ____________________

DEA License Expiration: ____________________

DEA Schedule: ___ II ___ III ___ IV ___ V ____________________

Has ever your license been disciplined/suspended/fined? YES☐ NO☐ If yes, when and why?

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OFFICIAL USE ONLY

SITE VERIFICATION: ____________________

NAME SIGNATURE SENIOR DENTAL SURGEON DATE

APPROVAL: ____________________

NAME SIGNATURE OF THE CHIEF DENTAL OFFICER DATE