THE DEPARTMENT OF HEALTH REGULATORY SERVICES
Health Practice Commission
3rd Floor, Government Administration Building Box 132
133 Elgin Avenue, Grand Cayman KY1-9000, CAYMAN ISLANDS
Telephone: (345) 949 -2813 / 946 -2084
Website: www.dhrs.gov.ky Email:HPC@gov.ky

Medical Report

Patient Name: _____ DOB: _____

I, the above applicant, by virtue of providing this medical report form, do hereby give authorization to my medical practitioner to disclose the information requested in this form to the Health Practice Commission – Council of Professions Allied with Medicine for the purposes of my application.

Applicant Signature: _____ Date: _____

Section 4(1) (g) of the Health Practice Regulations (2021 Revision) states:
"subject to sub-regulation (2), a report as to the physical and mental health of the applicant meeting the requirements of that sub-regulation and made no earlier than six months prior to application for registration;"

Section 4(2) of the Health Practice Regulations (2021 Revision) states:
"The report given under sub-regulation (1) (g) shall be given by the applicant's medical practitioner, who must not be related to the applicant by birth or marriage and must have known the applicant for a period of at least two years."

I, _____, a medical practitioner duly licensed (licence no._____) to practice medicine in (location), _____ (country) _____ do hereby affirm that (patient's name) _____ _____ ☐ is not / ☐ is of sound mental health. I have been this patient's medical practitioner for _____ years and can attest that the patient's physical health is in _____ condition and that the patient is able to perform their duties within the scope of _____ (profession).

Any comments on any medical condition that may affect your patient's ability to perform in their area of healthcare.

☐ No Comment(s)

_____
Date

_____
Signature, Medical Practitioner

Name,
Address &
Country
(Print, stamp and/or seal)

Phone _____ ***Fax*** _____

Email _____ @ _____