



THE DEPARTMENT OF HEALTH REGULATORY SERVICES  
Health Practice Commission  
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](http://www.dhrs.gov.ky) Email: [hpc@gov.ky](mailto:hpc@gov.ky)

# Character Reference

**Applicant Name:**

**DOB:**

*I, the above applicant, by virtue of providing this form do hereby give authorization to the referee to disclose the information requested in this form to the Department of Health Regulatory Services for the purposes of my application.*

[PLEASE PRINT CLEARLY or TYPE]

**State your profession and/or appointment title(s).** Kindly note that you must be “a person unrelated to the applicant by birth or marriage, being a person of good standing in the community in which the applicant resides or resided and who has known the applicant for at least four years and who is acceptable to the Registrar (including[but not limited to] an attorney-at-law, a notary public, justice of the peace or a minister of religion)” The Notary public who certifies any document for the applicant and the Physician completing the Medical Report is NOT acceptable as a referrer.

**Describe the capacity by which you have known the applicant.**

**Are you a person related to the applicant by birth or marriage?**

☐ Yes ☐ No *if yes, state relationship*

**Have you known the applicant for at least four (4) years?**

☐ Yes ☐ No *If yes, how many?*

**Please describe the Applicant's personal attributes.**

Special emphasis should be on character, personality, communication, responsibility, and reputation.

*I, the undersigned, am a person of good standing in my community. I do hereby affirm that I have completed the above reference and I am not aware of anything that might adversely affect the applicant's ability to safely and competently practice in their field.*

**Signature**

**Please provide your contact details in full (by print or stamp) and attach your business card or a copy of your professional picture ID card here.**

**Address**

**Date**

*Must be dated within 6 months of submitting the application*

**Phone**

**Fax**

**Print name**

**Email**