



THE DEPARTMENT OF HEALTH REGULATORY SERVICES

Health Practice Commission

Council of Professions Allied with Medicine

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

Health Practice REGISTER Information

For Official Use Only 1. Entry No	2. Date of Entry
--------------------------------------	------------------

3. Full name		
☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr	D.O.B. dd/mm/yy	Sex: ☐ M ☐ F
☐ Other _____		
Last Name		Middle Name (s)
First Name		Maiden Name

4. Nationality	
Place of birth	Nationality
Country of Passport	Immigration: Caymanian /Status Holder Permanent Resident Right to work Work Permit Holder Student

5. Address	
Local address: Mailing	Local address: Physical
P.O. Box KY -	# & Street District
Local telephone no(s) Mobile Home	
Overseas Address	Overseas telephone no
	Personal email
Affiliate / Employer / Facility	
Work address: Mailing	Work address: Physical
P.O. Box KY -	# & Street District
Telephone	Work email

6. Registered profession		
Registration Profession / Practitioner Type		
Specialty registration requested? ☐ No ☐ Yes	If yes, Specialty	

7. Professional qualifications		
Abbreviations after name		
Post Graduate Training	Start Date dd/mm/yy	
Address Country	End Date dd/mm/yy	
Qualification		
Post Graduate Training	Start Date dd/mm/yy	
Address Country	End Date dd/mm/yy	
Qualification		
Post Graduate Training	Start Date dd/mm/yy	
Address Country	End Date dd/mm/yy	
Qualification		
Post Graduate Training	Start Date dd/mm/yy	
Address Country	End Date dd/mm/yy	
Qualification		

For Official Use Only

8. Council's decisions, including any restrictions on practice:

☐ Deferred (and able/unable to work) for reasons listed below:

Deferred 1 date _____ Deferred 2 date _____ Deferred 3 date _____

☐ **DENIED - Reason:** _____

☐ Approved in Principle (and able/unable to work) upon receipt of documents listed below:

☐ Fully Approved as _____ (Classification)

(Specialty)

Comments _____

9. Details of Registration

a. Registration List: Principal *Provisional Institutional Registration List b.
Specialty

c. Additional Notes

10. Registration date

Expiration date

Registrar's remarks

Registrar's signature _____ Date _____