THE DEPARTMENT OF HEALTH REGULATORY SERVICES
Health Practice Commission
MEDICAL AND DENTAL COUNCIL
3nd Floor, Government Administration Building, Box 132
33 Elgin Avenue Grand Cayman KY1-9000, CAYMAN ISLANDS
Telephone: (345) 949 -2813 / 946 -2084, Fax: (345) 946 -2845
Email: HPBUSERS@gov.ky
Website: www.dhrs.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. ☐ Other_____	D.O.B. dd/mm/yy	**Sex:** ☐ M ☐ F
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 P.O. Box KY__-_____	Local address: Physical # & Street District
Local telephone no(s) Mobile	Home
Overseas Address	Overseas telephone no Personal email
Affiliate / Employer / Facility	
Work address: Mailing P.O. Box KY__-_____	Work address: Physical # & 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		

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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 _____