



THE DEPARTMENT OF HEALTH REGULATORY SERVICES

Health Practice Commission

**COUNCIL FOR PROFESSIONS ALLIED WITH MEDICINE**

3<sup>rd</sup> 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](mailto:HPBUSERS@gov.ky)

Website: [www.dhrs.gov.ky](http://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.

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

<b>6. Registered profession</b>	
Registration Profession / Practitioner Type	
Specialty registration requested? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Specialty

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

<i>For Official Use Only</i>	
<b>8. Council's decisions, including any restrictions on practice:</b>	
<input type="checkbox"/> Deferred (and able/unable to work) for reasons listed below: Deferred 1 date _____ Deferred 2 date _____ Deferred 3 date _____	
<input type="checkbox"/> <b>DENIED - Reason:</b> _____	
<input type="checkbox"/> Approved in Principle (and able/unable to work) upon receipt of documents listed below:	
<input type="checkbox"/> Fully Approved as _____ (Classification)	
<input type="checkbox"/> _____ (Specialty)	
Comments	
<b>9. Details of Registration</b>	
a. Registration List: <input type="checkbox"/> Principal <input type="checkbox"/> *Provisional <input type="checkbox"/> Institutional Registration List	
b. Specialty	
c. Additional Notes	
<b>10. Registration date</b>	<b>Expiration date</b>
Registrar's remarks	

Registrar's signature \_\_\_\_\_ Date \_\_\_\_\_