THE DEPARTMENT OF HEALTH REGULATORY SERVICES

Health Practice Commission

NURSING AND MIDWIFERY COUNCIL

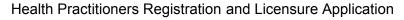
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☐ Mr. ☐ Mrs. ☐ Miss



In accordance with the Health Practice Law (2005 Revision), the following information shall be provided by the applicant to the Registrar of the Health Practice Councils for registration and license to practice in the Islands.

Last Name	Middle				
First	Maiden				
2. Nationality					
3. D.O.B. dd/month/yyyy					
4. Place of birth					
5. Permanent Address					
. E-mail address		Telephone:	ephone:		
7. PROFESSION:	Specialty request:				
8. PROFESSIONAL EDUCATION:					
Name and Location		Dates dd/mm/yy	Qualifications (degrees, etc.)		

9. PROFESSIONAL EXPERIENCE:		Dates (from-to)			
Name and Location	e and Location		dd/mm/yy	Additional details	
10. TWO PROFESSIONA	L REFEREES:				
Name		Title			
Address					
Name		Title	Title		
Address		1			

Nursing and Midwifery Council

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11. ONE PERSONAL REFEREE:

Name	Title				
Address					
12. DETAILS FOR REGISTRATION:					
Principal Registration to actively practicing in the Cayman Islathereof) *Provisional Registration for persons requiring further training Principal List *Institutional Registration to practice in a cabinet designated for the principal List is a cabinet designated for the practice in a cabinet designated for the principal List is a cabinet designated for the cabinet designated for the cabinet designated for the cabinet designated for the cabin	ng prior to being fully registered on the	* Specify dates for practitioners Provisional List; and			
13. Have you ever been arrested or convicted of a crime? No Yes If you have stated yes, state nature of charge(s), date(s) and disposition:					
14. Have you ever been the subject of professional disciplinary action? No Yes If you have stated yes, state nature of charge(s), date(s) and disposition:					
14A . I understand that once I am approved by the relevant Council, I shall be entered on the register; and I further understand that I am not permitted to practice until I obtain a practising licence or a practising licence is issued to me by the relevant Council.					
15. I understand that giving false or misleading information will result in cancellation of registration and forfeiture of the fee tendered. I hereby authorize the Council to investigate my background and contact my referees.					
dd/mm/yy Date Applicant's sig	nature				
16. Fee tendered \$ on the day of 20 .					

(Note: If further space is required, please use additional pages.)

17. For Official Use Only	Disposition of app	nlication:				
Date application and fee received: by (initials) Date fee paid to Treasury: by (initials) Investigator's report (if any) □ None □ Attached Date application presented to Council: Date of Council's decision on application: Additional Notes	□ Approved □ DENIED □ Deferred	□ Principal □ *Provisional □ Institutional				
Signature of Chairperson/Deputy Chairperson of the Council dd/mm/yy		Date				
This application is the property of the Government of the Cayman Islands, and will be kept in the confidential custody of the Registrar, Health Practice Councils.						