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, Fax: (345) 946 -2845
Website: www.dhrs.gov.ky Email: hpbusers@gov.ky

Medical Report

Patient Name: ____ DOB: __________________

I, the above applicant, by virtue of providing this medical report form, do hereby give authorization to my medical practitioner to disclose the information requested in this form to the Health Practice Commission – Medical and Dental Council for the purposes of my application.

Applicant Signature: ______________________________________ Date: ____________________

Section 4(1)(g) of the Health Practice Registration Regulations (2005 Revision) states:
"subject to subregulation (2), a report as to the physical and mental health of the applicant meeting the requirements of that subregulation and made no earlier than six months prior to application for registration;"

Section 4(2) of the Health Practice Registration Regulations (2005 Revision) states:
"The report given under subregulation (1)(g) shall be given by the applicant's medical practitioner, who must not be related to the applicant by birth or marriage and must have known the applicant for a period of at least two years."

I, ____, a medical practitioner duly licensed (licence no._______________) to practice medicine in __________________ (location), do hereby affirm that ____ (patient's name) ☐ is / ☐ is not of sound mental health. I have been this patient's medical practitioner for ____________ years and can attest that his/her physical health is in __________________ condition and that he/she is able to perform his/her duties within the scope of ____ (profession).

Any comments on any medical condition that may affect your patient's ability to perform in his/her area of healthcare.

☐ No Comment(s)

____
Date

____
Signature, Medical Practitioner

Name, Address & Country ***(Print, stamp and/or seal)***
Phone ________________________ ***Fax*** _______________________
Email ________________________________ @ ___________