



**THE DEPARTMENT OF HEALTH REGULATORY SERVICES**  
**Health Practice Commission**  
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## Health Care Facility Application

*In accordance with the Health Practice Law (2013 Revision), the following information has to be provided by the applicant to the Secretary/Chairperson of the Health Practice Commission for Certificate of operation, in the Islands.*

<b>1. Organisation Information</b>			
<input type="checkbox"/> New Application		<input type="checkbox"/> Relocation	<input type="checkbox"/> Satellite
<input type="checkbox"/> Renewal - Registration # _____		<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Laboratory
		<input type="checkbox"/> New Services	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Clinic	
<b>Name of Facility and/or Registered Company:</b>		<b>Address:</b> [street number] [district] [P.O Box- KY1]	
		<b>Island:</b> Grand Cayman/ Cayman Brac / Little Cayman	
<b>Office:</b> _____		<b>Office Email:</b> _____	
<b>Cell:</b> _____			
<b>Fax:</b> _____		<b>Website:</b> _____	
<b>Ownership:</b> [Owner Name/Company]		<b>Organisation Type</b> e.g. private, government (statutory authority)	
<b>2. Ownership Primary Contact:</b>			
<b>Name:</b> (last, first, middle, maiden) [Mr./Mrs./Miss/Ms./Dr.]		<b>Date of Birth:</b> _____	
		<b>Place of Birth:</b> _____	
<b>Registered profession:</b>		<b>Nationality:</b> _____	
<b>Council:</b> [MDC] [NMC] [PC] [CPAM]		<b>E-mail:</b> _____	
<b>Registration number:</b> _____		(expiry date) _____	
<b>3. Site Demographics.</b> List the buildings /locations in which care is provided to patients. List sites separately wherever there is a distinct separation of services (e.g. Diagnostic Services, Laboratory). Buildings with the same address or connected site should be considered as one site, but still need to list the specific services. (Use separate sheet if needed) <input type="checkbox"/> Check here if additional sheet is required			
Building Name	Location (# & Street)	Main or Additional Site	How many miles from main site?

**4. Staff Information:**

<b>Chief Executive Officer: (or equivalent)</b> [Mr./Mrs./Miss/Ms./Dr.]  Registered with: _____  Registration #: _____ (expiry date) _____	E-mail: _____
	Tel: _____
	Cell: _____
	Fax: _____

<b>Chief Medical Director: (or equivalent)</b> [Mr./Mrs./Miss/Ms./Dr.]  Registered with: _____  Registration #: _____ (expiry date) _____	E-mail: _____
	Tel: _____
	Cell: _____
	Fax: _____

<b>Inspection Coordinator:</b> <i>(provide contact information – this is for the staff member authorised to coordinate the inspection with the Health Practice and Facilities Inspector)</i> [Mr./Mrs./Miss/Ms./Dr.]	E-mail: _____
	Tel: _____
	Cell: _____

**5. Facility details**

<b>Type of health care facility</b>	<input type="checkbox"/> Hospital <input type="checkbox"/> Laboratory <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> Dental Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Spa Services <input type="checkbox"/> Other: _____
If the facility is a Hospital note the number of inpatient beds ( <i>currently in operation</i> ):	
If outpatient services are provided note the number of patient consultation rooms:	
Note the number of offices/administration rooms:	
Provide approximate square footage of health care facility:	

**List other work areas and their purpose:**

Work Area (e.g. Reception, Laundry)	Purpose (e.g. admissions, billing, sterilisation, cleaning)

**6. Clinical details:** List the types of Clinical Medical Services provided by the Organisation (*e.g., obstetrical, surgical, anaesthesia*).  Check here if additional sheet is required


**7. List major equipment:**  Check here if additional sheet is required


**8. Staff/Personnel/Employees list and insurance:**

a) Name of Doctor(s)	Registration number	Health Insurance	EXP DATE	Malpractice Insurance	EXP DATE

Check here if an additional sheet is required

b) Name of Other registered practitioners:	Registration number	Health Insurance	EXP DATE	Malpractice Insurance	EXP DATE

Check here if an additional sheet is required

c) Unregistered staff:	Health Insurance	EXP DATE

Check here if an additional sheet is required

FACILITY NAME \_\_\_\_\_ REGISTRATION # \_\_\_\_\_

1. Proof of Registration in Cayman Islands for Health Practitioners \_\_\_\_\_

*A copy of the certificate(s) or a certified print out from the Health Practice Commission*

2. Evidence of Medical Malpractice Insurance for Health Practitioners \_\_\_\_\_

*A copy of the certificate(s) (including expiration date), a letter from the insurer or a copy of the facility contract if blanket coverage exists*

3. Evidence of Health Insurance for all Employees \_\_\_\_\_

*A copy of employees' health card or receipt of most recent insurance payment, a copy of the letter from the insurance company or Department head in Government.*

4. Certificate of Public Liability Insurance \_\_\_\_\_

*Please attach a copy of your certificate or a letter noting expiration date*

5. Office / Practitioner Fee Schedule \_\_\_\_\_

*\*Please attach a copy of the Fee schedule*

6. Proof of Caymanian Status for Owner/Manager \_\_\_\_\_

*[As required by the Trade & Business Law (2007 Revision) section 13 and section 16, subsection (1)(a)]*

*\*Note – required for initial applicants and changes - Check here if this is not applicable*

7. Certificate of Occupancy [Dept. of Planning] \_\_\_\_\_

*Please attach a copy of your certificate.*

*\*Note – required for initial applicants and changes - Check here if this is not applicable*

8. Plans – *This is not applicable if it has already been provided. Check here  if both (a) & (b) are have been provided.*

New Application or Location – Plans of Office Space \_\_\_\_\_

Site Map(s) showing distribution of office(s) \_\_\_\_\_

***After fully understanding the following, please sign, have witnessed and date this form below:***

To the best of my knowledge, the above statements are correct. I understand that a copy of this form and any attachments that are needed to process this application will be shared with Administrative staff of the Health Practice Commission and the current membership of the Health Practice Commission.

I authorise the Health Practice Commission (HPC) to release only essential information, to process this application. I also give authorisation to the HPC to obtain records from practitioners, medical departments (private or public), insurer, employer, or any other relevant party on my behalf. I represent that I have the proper authority to execute this release.

**Signature:**

**Date (dd/mm/yy)**

**Print Name:**

**Alternate contact information if different from above:**

**Print Witness Name:**

**Signature of Witness:**

**Date (dd/mm/yy)**

*This application is the property of the Government of the Cayman Islands, and will be kept in the confidential custody of the Commission.*