THE DEPARTMENT OF HEALTH REGULATORY SERVICES
Health Practice Commission
3rd Floor Government Administration Building, 133 Elgin Avenue
Box 132 Grand Cayman KY1-9000, CAYMAN ISLANDS
Telephone: (345) 949-2813 or 946-2084
Website: www.dhrs.gov.ky Email: hpbusers@gov.ky

Health Care Facility Application

In accordance with the Health Practice Act (2021 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.

1.Organisation Information	☐ **New Application** ☐ **Renewal - Registration #_____** ☐ **Expansion- Registration #_____**	☐ **Relocation** ☐**Clinical Trials** ☐ **New Services** ☐**Clinic**	☐**Satellite** ☐**Laboratory** ☐**Other** _____

Name of Facility and/or Registered Company:	**Address:** *[street number] [district] [P.O Box- KY1]* **Island:** Grand Cayman/ Cayman Brac / Little Cayman
Office:_____ **Cell: _____** **Fax:_____**	**Office Email:_____** **Website:_____**
Ownership: [Owner Name/Company]	**Organisation Type** *e.g. private, government (statutory authority)*

2. Ownership Primary Contact:

Name: *(last, first, middle, maiden)* [Mr./Mrs./Miss/Ms./Dr.]	**Date of Birth:_____** **Place of Birth:_____** **Nationality: _____** **E-mail:_____**
Registered profession: **Council:** [MDC] [NMC] [PC] [CPAM] **Registration number:** (expiry date)_____	

3. Site Demographics. 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)* ☐ Check here if additional sheet is required

Building Name	Location (# & Street)	Main or Additional Site	How many miles from main site?

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4. Staff Information:	
Chief Executive Officer: *(or equivalent)* [Mr./Mrs./Miss/Ms./Dr.] Registered with:_____ Registration #:_____(expiry date)_____	E-mail: Tel: Cell: Fax:
Clinical Manager: *(or equivalent)* [Mr./Mrs./Miss/Ms./Dr.] Registered with:_____ Registration #:_____(expiry date)_____	E-mail: Tel: Cell: Fax:
Inspection Coordinator: *(provide contact information – this is for the staff member authorised to coordinate the inspection with the Health Practice and Facilities Inspector)* [Mr./Mrs./Miss/Ms./Dr.]	E-mail: Tel: Cell:

5. Facility details	
Type of health care facility	☐ Hospital ☐ Laboratory ☐ Outpatient clinic ☐ Dental Clinic ☐ Pharmacy ☐ Spa Services ☐ Other:_____
If the facility is a Hospital note the number of inpatient beds, chairs and /or clinical / examination rooms:	
If outpatient services are provided note the number of beds, chairs and /or clinical / examination 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

FACILITY NAME _____REGISTRATION #_____

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

8. Staff/Personnel/Employees list and insurance:

a) Name of Doctor(s)	Council Registration No.	Health Insurance	EXP DATE	Malpractice Insurance	EXP DATE

☐ Check here if an additional sheet is required

b) Name of Other registered practitioners:	Council Registration No.	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

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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. Photo Identification for the Owner, Medical Director and Inspection Coordinator _____ ☐
   Provide a copy of the passport or driver's license for the Owner, Medical Director and Inspection Coordinator

3. 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

4. Evidence of Health Insurance for all Employees_____ ☐
   Copy of the letter from the insurance company or Department head in Government

5. Certificate of Public Liability Insurance _____ ☐
   Please attach a copy of your certificate or a letter noting expiration date

6. Office / Practitioner Fee Schedule _____ ☐
   **Please attach a copy of the Fee schedule*

7. 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* ☐

8. 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* ☐

9. 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 showing distribution of office _____ ☐

   Site Map(s) showing aerial view of facility location _____ ☐

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.

Revised Jan 2021