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

Health Practitioners Registration and Licensure Application

In accordance with the Health Practice Act (2021 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.

1. ☐ Mr. ☐ Mrs. ☐ Miss	
Last Name	Middle
First	Maiden

2. Nationality
3. D.O.B. dd/month/yyyy
4. Place of birth

5. Permanent Address	
6. E-mail address	Telephone:

7. PROFESSION:	Specialty request:

8. PROFESSIONAL EDUCATION:

Name and Location	Dates dd/mm/yy	Qualifications *(degrees, etc.)*

9. PROFESSIONAL EXPERIENCE:

Name and Location	Dates (from-to) dd/mm/yy	Additional details

10. TWO PROFESSIONAL REFEREES:

Name	Title
Address	
Name	Title
Address	

11. ONE PERSONAL REFEREE:

Name	Title
Address	

12. DETAILS FOR REGISTRATION:

☐ Principal *Registration to actively practicing in the Cayman Islands for the year (or any remaining part thereof)* ☐ *Provisional *Registration for persons requiring further training prior to being fully registered on the Principal List* ☐ *Institutional *Registration to practice in a cabinet designated facility*	* **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 signature
16. Fee tendered $ on the day of 20 .	

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

17. For Official Use Only

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

Disposition of application:

Approved	Principal
DENIED	*Provisional
Deferred	Institutional

Signature of Chairperson/Deputy Chairperson of the Council

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 Registrar, Health Practice Councils.