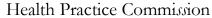
1.

First

Last Name

Mr Mrs Miss

THE DEPARTMENT OF HEALTH REGULATORY SERVICES



COUNCIL for PROFESSIONS ALLIED to MEDICINE

3rd Floor, Government Administration Building, Box 132 133 Elgin Avenue Grand Cayman KY1-9000, CAYMAN ISLANDS Telephone: (345) 949 -2813 / 946 -2084.

Email: HPBUSERS@gov.ky



HEALTH PRACTICE ACT (2021 Revision) 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.

Middle

Maiden

2. Nationality				
3. D.O.B. dd/month/yyyy				
4. Place of birth				
5. Permanent Address				
6. E-mail address		Telephone:	ephone:	
		pecialty request:		
7. PROFESSION:	Spec	ialty request:		
7. PROFESSION: B. PROFESSIONAL EDUCATION:	Spec	ialty request:		
	Spec	Dates	Qualifications (degrees, etc.)	
3. PROFESSIONAL EDUCATION:	Spec	Dates		
3. PROFESSIONAL EDUCATION:	Spec	Dates		
3. PROFESSIONAL EDUCATION:	Spec	Dates		
3. PROFESSIONAL EDUCATION:	Spec	Dates		
3. PROFESSIONAL EDUCATION:	Spec	Dates		

Council for Professions	Allied to Medicin	e		HPL Form A - Pa	age 2
PROFESSIONAL EXPER	IENCE:				
Name and Location			Dates (from-to) dd/mm/yy	Additional details	
0. TWO PROFESSIONAL	REFEREES:				
Name	Titl	Title			
Address					
Name	Titl	Title			
Address	1				

11. ONE PERSONAL REFEREE:

Name	Title	
Address		
12. DETAILS FOR REGISTRAT	ION:	
thereof)	in the Cayman Islands for the year (or any remaining part ring further training prior to being fully registered on the binet designated facility	* Specify dates for practitioners Provisional List: and
•		
•		
f you have stated yes, state nature of charge	fessional disciplinary action?	
f you have stated yes, state nature of charge	fessional disciplinary action?	
f you have stated yes, state nature of charge	fessional disciplinary action?	
	fessional disciplinary action?	

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

Date application and fee received: by (initials)	Disposition of application: Approved Principal				
Date fee paid to Treasury: by (initials) Investigator's report (if any) None Attached	DENIED	*Provisional			
Date application presented to Council:	Deferred	เกรแนนอกส			
Date of Council's decision on application:					
Additional Notes					
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.					