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
Website: www.dhrs.gov.ky Email: hpbusers@gov.ky

Registry Maintenance Administrative Form

Please provide your information in the far right column and note the statements below. Kindly read the below affirmations and confirm by initialling Items A, B, C, D & E. **This original document should be fully completed and returned to this office** within ten days of issue in order to update your record. Thank you.

		Changes / Corrections
Full name*		
Local mailing address*		
Address*		
Public telephone nos.		
Telephone #s		
Registration number*		**MDC**/_____/_____/_____
Practising Licence #s		
Overseas address**		
Overseas telephone #s.		
Date of Birth		
Country of Birth		
Nationality (ies)*		
Immigration status**		☐Caymanian / Status Holder ☐Permanent Resident ☐Work Permit Holder ☐Right to work ☐Student
Primary email (department use)		
Public email (for the Register)*		
Registered profession*		
Specialty registration*		
Professional qualification(s)*		
Name of your HealthCare Facility		
HealthCare Facility Registration number		**HPC/HCF/** _____
Sponsoring Registered Caymanian Practitioner		
Work mailing address		P.O. Box KY - Cayman
Work street address*		# Street District
Work email address		

* Information contained in the Register **Overseas information is required if you are a work permit holder
*** If you have status or have permanent residence please ensure your file has a certified copy of your certificate.

A. I understand that the Council should be notified of any changes "not less than fourteen days after [I have] received Notice of such matter" and giving false or misleading information may result in the removal of my name from the Register. _____**Initials required**

B. I am aware that any information contained in the Register (Form D) of the Health Practice Registration Regulations is Part of the public domain and can be provided to the public upon request. _____**Initials required**

C. I am also aware of and acknowledge the existence of the Medical and Dental Council's Code of Ethics and Standards of Practice dated 8 August 2008, published within Gazette No. 16, Supplement No. 5. _____**Initials required**

D. I shall only practice as a practitioner while I am in possession of a valid practising licence, issued by the Council in the prescribed Form on payment of the prescribed fee to the register _____**Initials required**

E. It is my responsibility as a registered practising practitioner to ensure that I have and maintain adequate and current Malpractice insurance, liability insurance, other relevant insurance or indemnity cover approved by the Commission. _____**Initials required**

Practitioner's Signature _____ Date _____