THE DEPARTMENT OF HEALTH REGULATORY SERVICES

Health Practice Commission

MEDICAL AND DENTAL COUNCIL

Government Administration Building 3rd Floor, **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

Practitioner's Conduct Statement

Practitioner's Name: _____

Registration Number: MDC/_____

Practitioner's Profession: _____

Health Care Facility Registration number: HPC/HCF/_____

Health Care Facility Name: _____

The Medical and Dental Council (MDC) requests that the medical director, owner, manager, human resources representative or department supervisor complete this form for all MDC practitioners. Please be guided by Section 30(6) (c) & (d) of the Health Practice Act (2021 Revision).

Over the last twenty-four (24) months, has this practitioner been subject to any professional disciplinary action as it relates to their practice? (This includes revocation or suspension of privileges at a facility).

☐ **Yes**, please comment on the date(s), incident(s) specifics and action(s) taken.
☐ Attached on letterhead

☐ **No**

Authorised signature: _____ **Date:** _____

Print name: _____ **Title:** _____

OFFICIAL USE ONLY

_____

_____

_____