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|  <p align="center"> <b>THE DEPARTMENT OF HEALTH REGULATORY SERVICES</b><br/> <b>Health Practice Commission</b><br/> <b>Government Administration Building Box 132</b><br/> <b>133 Elgin Avenue, Grand Cayman KY1-9000, CAYMAN ISLANDS</b><br/> <b>Telephone: (345) 949 -2813 / 946 -2084</b><br/> <b>Website: <a href="http://www.dhrs.gov.ky">www.dhrs.gov.ky</a> Email: <a href="mailto:hpbusers@gov.ky">hpbusers@gov.ky</a></b> </p>  |
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## 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 initialing 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*                                                                                                                                                                                                                    | <b>MDC/</b> _____ <b>/</b> _____ <b>/</b> _____                                                                                                                                                                       |                |
| Practising Licence #s                                                                                                                                                                                                                   |                                                                                                                                                                                                                       |                |
| Overseas address**                                                                                                                                                                                                                      |                                                                                                                                                                                                                       |                |
| Overseas telephone #s.                                                                                                                                                                                                                  |                                                                                                                                                                                                                       |                |
| Date of Birth                                                                                                                                                                                                                           |                                                                                                                                                                                                                       |                |
| Country of Birth                                                                                                                                                                                                                        |                                                                                                                                                                                                                       |                |
| Nationality (ies)*                                                                                                                                                                                                                      |                                                                                                                                                                                                                       |                |
| Immigration status**                                                                                                                                                                                                                    | <input type="checkbox"/> Caymanian / Status Holder <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Work Permit Holder <input type="checkbox"/> Right to work<br><input type="checkbox"/> 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                                                                                                                                                                                                 | <b>HPC/HCF/</b> _____                                                                                                                                                                                                 |                |
| 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<br>*** 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 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 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 practicing 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 practicing 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 \_\_\_\_\_