MINISTRY OF HEALTH AND CULTURE

P.O. BOX 110, GRAND CAYMAN, KY1-9000

PHONE: (345)244-2318

WEBSITE: WWW.MINISTRYOFHEALTH.GOV.KY

MEDICAL TOURISM PROVIDER APPLICATION FORM

IN ACCORDANCE WITH THE HEALTH PRACTICE LAW (2013 REVISION), THE FOLLOWING INFORMATION MUST BE PROVIDED BY THE APPLICANT TO THE MINISTRY OF HEALTH FOR DESIGNATION BY CABINET AS A MEDICAL TOURISM PROVIDER

Provider information:	☐New Provider	☐Existing Provider
Name of primary applicant:		
Physical address:		
P.O. Box:	Postal Code:	Country:
Telephone number:	Cell:	Work:
Email address:		
Owners/Directors/Operators (*Please list names and nationalities):*		

REQUIRED INFORMATION **(EXISTING PROVIDER)**	
Certificate of Operation from the Health Practice Commission	☐
Types/Scope of services provided	☐
Number of patients expected	
Please attach a copy of your certificate and/or supporting documents	

REQUIRED INFORMATION **(NEW PROVIDER)**	
Copy of Business Proposal	☐
Copy of records of current/prior registration in another jurisdiction	☐
Copy of latest financial report (audited)	☐
Types/Scope of services provided	☐
Proposed location for services to be provided	☐
Please attach a copy of your certificate and/or supporting documents	

I hereby declare that I have not filed or been adjudged bankrupt and the information provided in this form is true and correct.

Signature of applicant:	Date:
Print Name:	

Incomplete applications will not be submitted to Cabinet