THE DEPARTMENT OF HEALTH REGULATORY SERVICES
Health Practice Commission
COUNCIL FOR PROFESSIONS ALLIED WITH MEDICINE
3rd Floor, Government Administration Building, 133 Elgin Avenue
Box 132 Grand Cayman KY1-9000, CAYMAN ISLANDS
Telephone: (345) 949 -2813 / 946 -2084
**Email:** hpbusers@gov.ky **Website:** www.dhrs.gov.ky

## Practitioner's Conduct Statement

Practitioner's Name: _____

Registration Number: CPAM/_____

Practitioner's Profession: _____

Health Care Facility Registration number: HPC/HCF/_____

Health Care Facility Name: _____

The Council for Professions Allied with Medicine (CPAM) request that the owner, manager, human resources representative or department supervisor complete this form **biennially** for all CPAM practitioners under 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**

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