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

Student Nurse Registration Application

In accordance with the Health Practice Act (2026 Revision), the following information shall be provided by the applicant to the Registrar of the Health Practice Councils for registration and license to practice in the Islands.

1. ☐ Mr. ☐ Mrs. ☐ Miss	
Last Name	First
Middle	Maiden

2. Nationality
3. D.O.B. dd/month/yyyy
4. Place of birth
5. Country of Passport
6. Immigration Status: ☐ Caymanian/ Status Holder ☐ Permanent Resident ☐ Right to Work ☐ Work Permit Holder ☐ Student

7. Local Address: P.O. Box KY-	**8.** Street
9. District	**10.** E-mail address
11. Telephone: Home Mobile:	

12. School Address: P.O. Box KY-	**13.** Street
14. District	**15.** Telephone:
16. E-mail address	**17.** Website:

18. STUDENT DETAILS:

Include date of matriculation, student ID number expected date of graduation, verification by school	Dates (from-to) dd/mm/yy	Qualifications

19. ONE PERSONAL REFEREE:

Name	Title
Address	

20. DETAILS FOR REGISTRATION:

☐ *Provisional *Registration for persons requiring further training prior to being fully registered on the Principal List*	* **Specify dates** dd/mm/yyyy

21. Have you ever been arrested or convicted of a crime? ☐ No ☐ Yes
If you have stated yes, state nature of charge(s), date(s) and disposition:

22. *I understand that once I am approved by the Council, I shall be entered on the Provisional Register; and I further understand that I am not permitted to practice until I am provisionally registered by the Nursing and Midwifery Council.*

23. *I understand that giving false or misleading information will result in cancellation of registration. I hereby authorize the Council to investigate my background and contact my referee.*

Date: dd/mm/yyyy	Applicant's signature:
24. Fee tendered $ on the day of 20 .	

(Note: If further space is required, please use additional pages.)

25. For Official Use Only

Date application received: _____ by _____ (initials)

Investigator's report (if any) ☐ None ☐ Attached

Date application presented to Council: _____

Date of Council's decision on application:_ _____

Additional Notes: _____

_____

_____

Disposition of application:

☐ Approved
☐ DENIED
☐ Deferred

Signature of Chairperson/Deputy Chairperson of the Council _____

Date dd/mm/yyyy _____

This application is the property of the Government of the Cayman Islands, and will be kept in the confidential custody of the Registrar, Health Practice Councils.

Application Checklist

This list is a summary of general requirements for all applicants, the Council has the right to request additional documentation as it sees fit.

All documents must be in English, signed and dated within six month of submission to the Council - original signature required.

- ☐ Application Form, duly completed signed and dated by applicant.
- ☐ Passport-size photograph (with the date taken on the back)
- ☐ Letter of Verification, signed and dated from the University **including** programme start date
- ☐ Certified Copy of CXC transcript or equivalent examination transcript(s) or certificates(s)
- ☐ **Original** Character reference, duly completed dated and signed including applicants name and date of birth; a copy of business card or professional Id attached (referee must know applicant for at least 4 years).
- ☐ Police Clearance
- ☐ Certified copy of the picture page of applicant's Passport. (must be clear)
- ☐ A copy of your current Health Insurance card/coverage

Additional requirements

Applicant's Signature _____ Date_____