Medical and Dental Council
Cayman Islands Government

CONTINUING MEDICAL EDUCATION (CME) SUMMARY FORM

Name:_____ **Registration Number:** _____

NEW: CMEs completed within the three (3) years period prior to submission of application

RENEWAL: CMEs must be completed within the two (2) years period prior to submission of application

Please select which option applies to your profession ONE of A, B or C

A ☐ **50 hours required (includes general and 25 hours related to your area of specialty)**

☐ Medical Doctor ☐ Osteopaths (trained in the United States of America)
☐ Dentist ☐ Podiatrists

Specialty (if applicable): _____

B ☐ **30 hours required (includes general and 15 hours related to your profession)**

☐ Dental Hygienists ☐ Dental Therapist

C ☐ **20 hours required (includes general and 10 hours related to your profession)**

☐ Dental Assistants ☐ Dental Technicians

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KY1-9000

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CONTINUING MEDICAL EDUCATION (CME) SUMMARY FORM CONT'D

Name:_____ **Registration Number:** _____

Please list your CME class(es)/programme(s) completed and attach the original certificates in the same order.

TYPES OF CONTINUING EDUCATION	NOTE
LIVE – Webinar/In-person **INTERNET – Online programmes/courses** **WORK – On the job improved knowledge and skills, with written proof signed by supervisor** **FORMAL – Institutional education/school**	**~ Two hours CME dedicated to Ethics.** **~ CMEs' submission of 10 hours or more requires a breakdown/outline/transcript/ of topics discussed from the sponsor/provider.** **~CME certificates should be submitted in order as written on the below table.**

Title of CME Program	CME Sponsor/Provider	Type of CME (Live, Internet, Work, Formal)	Date (Date/Month/Year)	Hours Completed
General CMEs				

Area of Specialty CMEs (if applicable)				
			Total:	

I certify that the above statement is a true and accurate record of the Continuing Medical Education programs I completed. I am aware that any deliberate falsification included in this document will constitute a breach of good faith and result in the loss of one's license to practice.

Signature:_____ **Date:** _____