



## MINISTRY OF HEALTH AND CULTURE

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

PHONE: (345)244-2318

WEBSITE: [WWW.MINISTRYOFHEALTH.GOV.KY](http://WWW.MINISTRYOFHEALTH.GOV.KY)

### MEDICAL TOURISM FACILITY 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 FACILITY

Facility information:	<input type="checkbox"/> New Facility	<input type="checkbox"/> Existing Facility
Name of facility:		
Physical address of facility:		
Parcel:	Block:	
Name of primary applicant:		
P.O. Box:	Postal Code:	Country:
Telephone number:	Cell:	Work:
Email address:		
Owners/Directors/Operators ( <i>Please list names and nationalities</i> ):		

### REQUIRED INFORMATION (EXISTING FACILITY)

Have you been designated as a medical tourism provider by Cabinet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, have you submitted an application for designation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the facility exclusively for medical tourism services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical tourism services will be provided by	<input type="checkbox"/> Single provider	<input type="checkbox"/> Multiple providers
Certificate of Operation from the Health Practice Commission	<input type="checkbox"/>	
Types/Scope of services provided	<input type="checkbox"/>	
Number of patients expected		
<i>Please attach a copy of your certificate and/or supporting documents</i>		

### REQUIRED INFORMATION (NEW FACILITY)

Copy of business proposal	<input type="checkbox"/>	
Copy of records of current/prior registration in another jurisdiction	<input type="checkbox"/>	
Copy of latest financial report (audited)	<input type="checkbox"/>	
Types/Scope of services to be provided	<input type="checkbox"/>	
Number of patients expected		
Certificate of Occupancy from the Planning Department	<input type="checkbox"/>	
Certificate of Operation from the Health Practice Commission	<input type="checkbox"/>	
Have you been designated as a medical tourism provider by Cabinet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, have you submitted an application for designation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the facility exclusively for medical tourism services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical tourism services will be provided by	<input type="checkbox"/> Single provider	<input type="checkbox"/> Multiple providers
<i>Please attach a copy of your certificate and /or supporting documents</i>		

Signature of applicant	Date
Print Name	

*Incomplete applications will not be submitted to Cabinet*