



**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 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:	<input type="checkbox"/> New Provider	<input type="checkbox"/> Existing Provider
Name of primary applicant:		
Physical address:		
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 PROVIDER)**

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 PROVIDER)**

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 provided	<input type="checkbox"/>
Proposed location for services to be provided	<input type="checkbox"/>
<i>Please attach a copy of your certificate and/or supporting documents</i>	

*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*