



REQUIREMENTS FOR ADMISSION TO RESIDENCY PROGRAMS:

1. **One Original** Application Form and One Copies
2. **One Copy** Transcripts of Premedical Education
3. **One Copy** Transcripts of Medical Education
4. Document Dean Lettes's /School Graduate (MSPE)
5. **One Copy** Certified Transcripts Score (USMLE)
6. If foreign graduate: **ECFMG**
7. If you have Puerto Rico Board of Licencing and Medical Disciplines
8. Certificate of no Penal Record from local area and Department of Public Security
9. **Curriculum Vitae actualized to the current year**
10. **Personal Statement**
11. **Letters of recommendation two (2) actualized to current year (for Family Medicine Residency one letter of recommendation of a Family Physician)**
12. **One Copy** University/School Diploma Graduate Medicine
13. Two (2) recently photos
14. Fluency in both: Spanish and English Language
15. Evidence of all administered vaccines including: Hepatitis, Chicken Pox and Influenza

All documents should be sent to:

Mayagüez Medical Center
Graduate Medical Education Office
Hostos Avenue # 410
Mayagüez, PR 00680



**Mayagüez
Medical Center**
Dr. Ramón Emeterio Betances



**Graduate Medical Education
Residency Program Application**

**Photo 2 x 2
2. Social Security Number**

1. Name (Last –Paternal – Maternal) (First) (Middle)

XXX XX _____

Internal Medicine _____
Date

Level _____

Family Medicine _____
Date

Level _____

3. Permanent Address (Street)

4. Phone Number (Home)

() -

5. Mailing Address (Street)

6. Phone Number (Cellular)

() -

(City) (State) (Zip)

7. Citizenship: US

other: _____

8. Name of person through whom I can always be contacted (Phone)

9. Civil Status

married single

(City) (State) (Zip)

10. Date of Birth

(month/ day/ year) _____ / _____ / _____

11. E-mail address

12. Birth Place: _____

13. Do you speak and write Spanish? speak write both

UNDERGRADUATE EDUCATION

14. University (s) (Name)

(City) (State)

15. Month / Admission to University 16. Month / Year of (anticipated) Graduation

15. Honors/ Awards

GRADUATE EDUCATION

16. Medical School	Dates Attended	Graduate Degree	Area of Study
From _____	To _____	(If any)	

a. Name

(City) (State)

INTERNSHIP OR RESIDENCY PROGRAM

17. a. Name

(City) (State) (Year) From: _____ To _____

b. Name

(City) (State) (Year) From: _____

23. Have you ever been involved in, or pending, any malpractice actions?

Specify: _____

24. Do you have or have had any physical or mental illness that in any way interfere with the proper performance of your duties as a physician? [] yes [] no

Specify: _____

25. Have you been convicted for any felony charges? [] yes [] no

Specify: _____

26. References; list below the name and address of your references and ask them to write a letter directly to the Director of Graduate Medical Education with copy to the Director of the Residency Program. The reference should be physicians who have supervised you direct.

a. (Name)

b. (Name)

Address: (Street)

Address: (Street)

(City) (Street) (Zip)

(City) (Street) (Zip)

INSTRUCTIONS

- 1. Enclose copy diplomas, and certified transcripts of Premedical and Medical Education.**
- 2. If graduate from foreign University or Hospital, documents must be legalized.**
- 3. Submit one original and one copy of this application.**

I certify that all the information is correct and authorize to consult or request information about it.

Signature of applicant: _____ Date: _____

DO NOT WRITE BELOW THIS LINE: FOR MEDICAL EDUCATION OFFICE USE ONLY.

Action taken by Admission Committee:

[] Admitted [] Not admitted [] Alternate