

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 University/ School Graduate**
- 5. If foreign graduate: Legalized University/ School documents**
- 6. One copy Certified Transcripts Score (USMLE)**
- 7. Puerto Rico Board of Licensing and Medical Disciplines**
- 8. If foreign graduate: ECFMG**
- 9. Certificate of no Penal Record from local area Department of Public Security**
- 10. Letters of recommendation (two) actualized to current year (for Family Medicine Residency one letter of recommendation of a Family Physician)**
- 11. University/School Diploma Graduate Medicine**
- 12. Fluency in both Spanish and English Language**
- 13. Two (2) recently photos**
- 14. Curriculum Vitae actualized to the current year**
- 15. Personal Statement**
- 16. Evidence of all administered vaccines including Hepatitis/ Chicken Pox and Influenza**

All documents should be sent to:

**Mayaguez Medical Center
Graduate Medical Education Office
Hostos Avenue # 410
Mayaguez, P. R. 00680**

Tel: (787)652-9200 ext. 72219 (787) 833-5544

e-mail: espana.rodriguez@mayaguezmedical.com



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



**Graduate Medical Education
Residency Program Application**

Photo
2. Social Security Number

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

_____-_____-_____

I am applying for the following program starting on:

☐ 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)

(City) (State) (Zip)

9. Visa Status (If applicable)
☐ Permanent Resident
☐ Temporary

Specify: ☐ J-1 ☐ H-1

10. Date of Birth

(month/ day/ year) ____/____/____

11. Civil Status

☐ married ☐ single

12. Birth Place: _____

13. E-mail address

14. Do you speak and write Spanish? ☐ speak ☐ write ☐ both

MEDICAL EDUCATION

15. Medical School (s) (Name) _____

(City) (State) _____

16. Month/ Year of Admission to Medical School **17. Month/ Year of (anticipated) Graduation**
From: _____ **To:** _____ **From:** _____ **To:** _____

18. Honors/ Awards: _____

GRADUATE EDUCATION

19. Graduate School **Dates Attended** **Graduate Degree** **Area of Study**

From _____ To _____
a. Name _____

(City) (State) _____

b. Name _____

(City) (State) _____

INTERNSHIP OR RESIDENCY PROGRAM

20. a. Name _____

(City) (State) (Year) _____

b. Name _____

(City) (State) (Year) _____

UNDERGRADUATE EDUCATION

21. Undergraduate College (s) **Dates Attended** **Graduate Degree** **Mayor**

a. Name _____

From _____ To _____

(City) (State) _____

b. Name _____

From: _____ To _____

(City) (State) (Year) _____

RELEVANT WORK EXPERIENCE

22. Name and Location of Employer

Position

Month and Year

From _____ To _____

23. Additional information or special qualification such as membership in medical societies, publications, ect.

LICENSURE STATUS

24. I am planning to take or have already passed the examination checked below; please, write the score obtained.

☐] PUERTO RICO BOARD OF LICENSING AND MEDICAL DISCIPLINE

I. _____
(Score) (Date)

II. _____
(Score) (Date)

III. _____
(Score) (Date)

Permanent License Number: _____

☐] USMLE/ NATIONAL BOARD:

STEP I	_____ / _____
STEP 2 CK	_____ / _____
STEP 2 CS	_____ / _____
STEP 3	_____ / _____

☐] ECFMMG Certificate Number: [] - [] [] [] - [] [] [] - [] []

OTHER INFORMATION

25. Do you have any commitment with the Armed Forces ☐] yes ☐] no

Specify: _____

26. Are you participating in the National Matching Program? ☐] yes ☐] no

Specify: _____

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

Specify: _____

28. 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: _____

29. Have you been convicted for any felony charges? ☐ yes ☐ no

30.

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 references should be physicians who have supervised you directly.

a. (Name)

b. (Name)

_____ Address: _____ Add
ress: (Street) Address: (Street)

_____ (City) (State) (Zip) (City) (State) (Zip)

**MAYAGUEZ MEDICAL CENTER
DR. RAMON EMETERIO BETANCES IS A DRUG FREE INSTITUTION:
THEREFORE DRUG TESTING IS A REQUISITE FOR A CONTRACT.**

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