Mayagüez
Medical Center
Dr. Ramón Emeterio Betances

MAYAGUEZ MEDICAL CENTER
FAMILY MEDICINE RESIDENCY PROGRAM
PO BOX 600
MAYAGUEZ, PR 00681

APPLICANT NAME:___________________________________

REQUIREMENTS FOR ADMISSION TO RESIDENCY PROGRAM:

____1. Complete Application Form

____2. Copy Transcripts of Premedical Education

____3. Copy Transcripts of Medical Education

____4. Copy Document Dean Letter's /School Graduate (MSPE)

____5. Copy Certified Transcripts Score (USMLE)

____6. If foreign graduate: <u>ECFMG Certificate</u>

____7. If you have Puerto Rico Board of Licensing and Medical Disciplines

____8. Certificate of no Penal Record

____9. Curriculum Vitae actualized to the current year

___10. Personal Statement

___11. Letters of recommendation two (2) actualized to current year (one letter of recommendation of a Family Physician)

___12. Copy University/School Diploma Graduate Medicine

___13. One (1) recently 2x2 photo

___14. Fluency in both: Spanish and English Language

___15. Evidence of all administered vaccines including: Hepatitis, Chicken Pox, COVID and Influenza

___16. ID with photo or passport / S.S

All documents should be sent to:

Email: residencyfamilymedicine2012@gmail.com

FAMILY MEDICINE RESIDENCY PROGRAM APPLICATION

	Attached Recent Photograph
____ **1. Name (Last –Paternal – Maternal) (First) (Middle)** **Preferred Name:**__________________________________	**2. Social Security Number** XXX - XX ___ ___ ___ ___

[ ] **Family Medicine** _________________ **Start Date** **Level** _____________________

3. Permanent Address (Street)	**5. Phone Number** ( ) -
4. Mailing Address (Street) ____________ ____________ ____________ **(City)** **(State)** **(Zip)**	**6. I identify my gender as:** ❑ Man ❑ Woman ❑ Genderqueer/Non-Binary ❑ ______ (fill in the blank) ❑ Prefer not to disclose
7. Name and phone number of person through whom I can always be contacted (Phone)	**8. Citizenship:** [ ] **US** [ ] **other:** ____________________
9. Date of Birth **(month/ day/ year)** __________ / ________ / _________	**10. Civil Status** [ ] **married** [ ] **single**
11. Birth Place: ________________________________	**12. E-mail address**
13. Do you speak and write Spanish? [ ] **speak** [ ] **write** [ ] **both**	

GRADUATE MEDICAL EDUCATION

14. Medical School (s) Name

____

____

(City) (State)

15. Month/Year of Admission to Medical School	**16. Month/Year of anticipated Graduation**

Honors/Awards

UNDERGRADUATE EDUCATION

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

From _________To ___________ **(If any)**

a. Name

(City) (State)

b. Name

(City) (State)

FAMILY MEDICINE RESIDENCY
MAYAGUEZ MEDICAL CENTER

INTERNSHIP OR RESIDENCY PROGRAM

17. a. Name **(Year) From: ____________ To _________**	**(City)** **(State)**
b. Name **(Year) From: ____________ To _________**	**(City)** **(State)**

RELEVANT WORK EXPERIENCE

18. Name and Location of Employer	Position	Month and Year	
		From	To

19. **Additional information or special qualification such as membership in medical societies, publications, ECT.**

____

LICENSURE STATUS

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

[ ] PUERTO RICO MEDICAL BOARD

I. ____________ ________________
(Score) **(Date)**

II.____________ ________________
(Score) **(Date)**

III.____________ ________________
(Score) **(Date)**

Permanent License Number: ____

[ ] USMLE/ NATIONAL BOARD: STEP I. ______/_____ **STEP 2 CK** _______/______

STEP 2CS. ______/______ **STEP 3** _______/______

[ ] FLEX: I. ________ **II.**_________ **III.**__________

____

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

____

OTHER INFORMATION

21. Do you have any commitment with the Armed Forces [ ] yes [ ] no

Specify: ___

____

22. Are you participating in the National Matching Program? [ ] yes [ ] no

Specify: ____

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. The reference should be physicians who have supervised you directly. Two letters of recommendations must be sent.

a. (Name)	**b. (Name)**
Address:	**Address:**
(City) (Zip)	**(City) (Zip)**

INSTRUCTIONS

1. **Enclose one recent photograph, copy of diplomas, and certified transcripts of Premedical and Medical Education.**
2. **If graduate from foreign University or Hospital, documents must be legalized.**

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