REQUISITOS DEL PROGRAMA DE INTERNADO:

1. Certificado de Buena Conducta
2. Copia de Diploma de Escuela de Medicina
3. Dos Cartas de Recomendación
4. Carta del Decano de la Escuela de Medicina (Dean's Letter)
5. USLME Step. 1 y 2
6. 1 Foto 2x2
7. C.V.
8. Transcripción de Crédito Escuela de Medicina

Los documentos antes mencionados pueden ser copias de los originales, sólo se aceptan solicitudes completas. Solicitudes parciales o falta de documentos, no se van a considerar. De no tener un documento lo antes mencionado, el candidato deberá tramitar el mismo y entregar copia junto con la aplicación. Toda solicitud y/o documento debe ser enviada por correo electrónico al internadomd@oncologicopr.org. Favor no enviar documentos por separado, debe adjuntar la solicitud con cada uno de los documentos mencionados.

Cordialmente,

Sra. Lizmarie Negrón Báez
Coordinadora Programa de Internado
787-763-4149 ext. 1901
email: lizmarie.negron@oncologicopr.org
internadomd@oncologicopr.org

Action taken by Office of Admission Committee Program Hospital
□ Admitted
□ Not Admitted

Department of Health
Office of Post-Graduate Medical Education
San Juan, Puerto Rico

Attach recent Photograph

APPLICATION FOR POSITION IN POST-GRADUATE MEDICAL EDUCATION TRAINING PROGRAM

1. Name: (Last: Paternal-Maternal) (First) (Middle)

2. Social Security Number:

I am applying to the following graduate program:

☐ **Internado**

Date:

Name Hospital: Hospital Oncológico Dr. Isaac González Martínez

3. Permanent Address: (Street)
(City) (State) (Zip)

4. Phone Number (Home)
( ) _______ - ___________

5. Phone Number (Office)
( ) _______ - ___________

6. Mailing Address: (Street)
(City) (State) (Zip)

7. Citizenship:
☐ US ☐ Other:___________

8. Visa Status (If applicable)
☐ Permanent
☐ Temporary: Specify: __ J1__H1

9. Name and phone of person through whom I can always be contacted: (Phone)
(City) (State) (Zip)

10. Civil Status:
☐ married ☐ single

11. Date of Birth:

12. Birth Place:

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

14. LICENSURE STATUS:

I am planning to take or have already passed the examinations checked below:
(please write the score obtained)

☐ Puerto Rico State Board:	I.___	II.___	III.___	Permanent License Number: ________	
☐ FLEX:	I.___	II.___	III.___	Date:	
☐ USMLE:	I.___	II.___	III. ___	CS: ___	**ECFMG Certificate Number:** _____-_________-_________-_____

15. MEDICAL EDUCATION

16. Medical School (s): (Name) (City) (State)

17. Month/Year of Admission:

16. Month/Year of Graduation:

18. Honors Awards:

18. GRADUATE EDUCATION

Graduate School: Dates Attended Graduate Degree Area of Study

a. Name:
(City) (State)

b. Name:
(City) (State)

19. INTERNSHIP OR RESIDENCY TRAINING

a. Name:		b. Name:	
(City)	(State)	(City)	(State)

20. REVELANT WORK EXPERIENCE

Name and Localization of Employer	Position	Month and Year	
		From	To
a.			
b.			
c.			

21. Additional information or special qualifications such as membership in medical societies, publications, etc.

a.	c.
b.	d.

22. OTHER INFORMATION

a. Do you have any commitment with the Armed Forces: ☐ Yes ☐ No
Specify:

b. Are you participating in the National Matching Program? ☐ Yes ☐ No
Specify:

c. Have you ever involved in, or pending, any malpractice actions?
Specify:

d. Do you have or have had any physical or mental illness that might in anyway interfere with the proper performance of your duties as a physician? ☐ Yes ☐ No
Specify:

e. Have you been convicted of any felony charges? ☐ Yes ☐ No
Specify:

23. References: List name of your references and ask them to write directly to the Director of Medical Education with a copy to the Chairman of the respective Department (these should be physicians who have supervised you directly. Two letters of recommendation must be submitted.

a. Name:		b. Name:	
(Address)		(Address)	
(City)	(State)	(City)	(State)

24. INSTRUCTION

a. Enclose, one recent photograph, diplomas, certified transcripts of Premedical and Medical Education.
b. Certificate of No Penal Record
c. Recommendation Letters (Two)
d. Dean's Letter
e. See attachment for further document's instructions (CK LIST)

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

Signature of Applicant:	Date: