Commonwealth of Puerto Rico
Department of Health
PUERTO RICO BOARD OF MEDICAL LICENSURE AND DISCIPLINE

(rev. december 2018 smn)

Date received:	License Number:
Fee paid:	Issued date:

APPLICATION FOR LICENSURE TO PRACTICE MEDICINE IN PUERTO RICO

(Every false statement knowingly made by the applicant in this paper or omits at by him/her in any clause in this application is good cause for rejection or for revocation of license after license has bee granted.)

I hereby make application for an examination to obtain a license to practice Medicine and Surgery in Puerto Rico and submit the following statements under oath.

Affix autographed photograph of Applicant (Passport photograph requested taken not more than six (6) months before the date of application. Must be pasted in this space and must not be larger than the space provided and must no be smaller than 3" by 3".

Affix Notary Seal on Photograph

(SEAL)

AFFIDAVIT NO._____

State or territory_____

_____
(Name of applicant)

Being duly sworn says that he(she) is the person referred to in this application and that the statement herein contained are true in every respect and that the photograph is a true likeness of him/her self within the last six months.

_____
Signature (applicant)

Suscribed and sworn to before me this_____ day of _____

20_____.

My commission expires_____

_____
Signature Notary Public

THE APPLICANT MUST GIVE FULL ANSWERS TO THE FOLLOWING:

Name:_____ Social Security #_____
Father last name/ Mother last name First name Middle

Date of Birth:_____/_____/_____ Place of Birth:_____ Age:_____
Month Day Year City State or Country

Address:_____

Postal address:_____ Phone:_____

Father's name_____ Mother's name_____

**Applicant must notify any change of address or name (marriage).

Native of_____ Are you a citizen of the United States?_____

If naturalized, give date and place of naturalization_____

_____

Color of hair_____ Color of eyes_____ Height_____ Weight_____

Have your surname ever been changed? Yes_____ No_____ If so, give date and place of such change and original surname._____

Have you ever practice medicine ilegally? Yes_____ No_____

Have you ever been convicted of or indicted for any crime? Yes_____ No_____

If so, state facts of the case here or on a separate sheet and attach._____

_____

_____

Have you read carefully and fully understand the Law (Act No. 139-2008, as amended which regulates the medical profession in Puerto Rico) and the Manual Orientation containing the information and rules governing the examination? Yes_____ No_____

Are you licensed in any state of the Union? Yes_____ No._____ What State?_____

I hereby expressly waive all provisions of Law forbidding any physician or other person who has attended or examined me or who hereafter attends or examines me from disclosing any knowledge or information which he thereby acquired and I hereby consent that he may disclose such knowledge or information to Puerto Rico Board of Medical Licensure and Discipline.

HIGH SCHOOL EDUCATION

I graduated from High School_____

on the _____ day of _____de _____.

COLLEGE OR UNIVERSITY EDUCATION

(Pre-medical education established by Act No. 112 of June 4, 1980, as amended)

Name and location of institution atended _____

_____

Period of attendance (For example August 1979 thru May 1980)

1st Year_____ 3rd Year_____

2nd Year_____ 4th Year_____

I received the degree of_____ From _____
College or University

on the _____ day of _____ de _____.

Cumulative Grade Point Average _____ (**Applicants must have maintained at least a 2.5 average**)

(In addition to the above, the applicant is required to furnish an official transcript from the Collage or University with subjects and grades to be sent directly to the Puerto Rico Board of Medical Licensure and Discipline.)

MEDICAL EDUCATION

At _____
Name of College or University and location

from the_____ day of_____, _____ to the_____day of_____, _____
month year month year

At_____
Name of College or University and location

from the_____ day of_____, _____ to the_____ day of_____, _____
month year month year

At_____
Name of College or University and location

from the_____ day of_____, _____ to the_____ day of_____, _____
month year month year

I was (will be) granted a Diploma as Doctor in Medicine by_____

located at_____ on the_____ day of _____, _____.

(In addition to the above applicant must have his _____ record, subjects, grades and title certified by the Registrar of the College or University and sent directly to the Puerto Rico Board of Medical Licensure and Discipline.)

CERTIFICATE OF GOOD MORAL CHARACTER OF THE APPLICANT

(Signed by two physicians duly authorized to practice in Puerto Rico whose regular licenses are in good standing.)

1) This CERTIFIES that I have been personally acquainted with Dr._____ for_____ years that I know_____ to be of good moral character and hereby recommend_____ to the Puerto Rico Board of Medical Licensure and Discipline as entirely worthy of examination for a license to practice medicine in Puerto Rico pursuant to Law.

_____ _____
Physician's Name Physician's Signature

Address_____

_____ Phone #_____ License #_____

2) This CERTIFIES that I have been personally acquainted with Dr._____ for_____ years that I know_____ to be of good moral character and hereby recommend_____ to the Puerto Rico Board of Medical Licensure and Discipline as entirely worthy of examination for a license to practice medicine in Puerto Rico pursuant to Law.

_____ _____
Physician's Name Physician's Signature

Address _____

_____Phone #_____ License#_____

APPLICATION FOR REGULAR LICENSE BY ENDORSEMENT

By this means I apply to the Puerto Rico Board of Medical Licensure and Discipline for the granting of a regular license to practice the profession. I submit the following information:

Name_____
Father's last name Mother's last name Name Middle name

Postal/home address_____

_____

Telephones: celular _____ other:_____

e-mail:_____ **Social Security #**_____/_____/_____

Birthdate: _____/_____/_____ **City and Country:**_____
month day year

Medical degree:_____/_____
Institution's name Graduation date

Internship:_____/_____
Institution's name Date

I request this license by means of:

_____Puerto Rico Examination _____Endorsement Date_____ Place_____

_____FLEX _____NBME _____USMLE Date_____ Place_____

Do you have a United States license? Yes_____ No_____ Indicate_____

Inform the purpose for which you are applying for a regular license:

_____**Work** _____**In Puerto Rico** _____**Outside of Puerto Rico** _____**To do Residency (Specialty)**

Place_____ **Specialty**_____ **Other**_____ **Indicate**_____

Have you been convicted of a felony or a misdemeanor in Puerto Rico or in any other state or country? Yes_____ No_____

Have you been under medical treatment for having depended on or used drugs or alcohol? Yes_____ No_____

Have you been hospitalized for a mental illness, addiction to drugs or alcoholism? Yes_____ No_____

Have you been convicted of illegally practicing medicine, acupuncture, any specialty not certified by the Board of Medical Examiners or any other profession in Puerto Rico or in any other state or country? Yes_____ No_____

Have you ever been arrested or summoned into court or summoned into court as a defendant or fined or imprisoned or placed on probation or has any case against you been filed or have you ever for field collateral for breach or violation of any law or police regulation or ordinance whatsoever? Yes_____ No_____

I CERTIFY THAT ALL INFORMATION ABOVE IS CORRECT AND TRUE

_____ _____
Date **Applicant's Signature**

(Rev. December 2018 smn)

C E R T I F I C A T I O N

TO: PUERTO RICO BOARD OF MEDICAL LICENSURE AND DISCIPLINE

I _____ as _____
(Dean Registrar)
of the School of Medicine _____ of the University of
(Name of School)
_____.
(Name and address)

CERTIFY: That _____ was registered on _____as a student of the School of Medicine and has approved all subjects of Basic and Clinical Sciences pertaining to the official and applicable Medical Curriculum Program or Study Plan.

I also certify that the above mentioned student graduated from the School of Medicine on _____ and received the degree _____ and that the photograph attached to this application is that of the above mentioned student.

In witness whereof, I have hereunto set my hand and affixed the Seal of the University, this _____ day of _____.

Affix

Photograph

2 x 2

_____
Signature

Important: This certification must be sent directly by the University to:
PUERTO RICO BOARD OF MEDICAL LICENSURE AND DISCIPLINE
PO BOX 13969
SAN JUAN PR 00908-5035

AFFIDAVIT

AFFIDAVIT Núm. _____

_____, _____ resident of
(Name) (Marital Status)
_____, of legal age, and known to me personally dully swears before me that he(she) is _____ of _____
(Dean Registrar) (Name of the School of Medicine)
and that the certification made above is to his(her) best knowledge and belief the whole truth.

_____ _____
Date Signature of Notary Public

CERTIFICACION

A LA JUNTA DE LICENCIAMIENTO Y DISCIPLINA MEDICA DE PUERTO RICO:

Yo, _____en mi carácter de

_____ de la Escuela de Medicina _____
(Decano Registrador) (Nombre de la escuela)

de la Universidad de _____.
Nombre y dirección

CERTIFICO: Que _____
Nombre del estudiante

se matriculó como estudiante de la Escuela de Medicina el día ____ de _____de_____ y cursó todas las materias del currículo, pensum o plan de estudios de medicina (Ciencias Básicas y Clínicas) aplicable y oficial.

Certifico además, que el estudiante antes mencionado se graduó de esta Escuela el día _____ de _____ de _____ recibiendo el grado de _____.

Certifico por último que la fotografía que aparece en esta certificación es del estudiante antes mencionado. Y para que así conste, firmo y sello la presente en _____ a _____ de _____de _____.

Foto
2 x 2
reciente

_____

NOTA: Esta certificación deberá ser enviada directamente por la Universidad a:
Junta de Licenciamiento Disciplina Médica de Puerto Rico
PO Box 13969
San Juan, Puerto Rico 00908

AFFIDAVIT

AFFIDAVIT Núm. _____

_____ vecino de _____,
(Nombre del funcionario)
mayor de edad y a quien conozco personalmente, debidamente juramentado, jura ante mí que es el _____ de _____
(Decano Registrador) (Nombre de la Institución)
y que la certificación que antecede es cierta a su mejor entender y creencia.

_____ _____
Fecha Firma Notario

GOBIERNO DE PUERTO RICO
Departamento de Salud

FORMULARIO DE CERTIFICACIÓN MÉDICA
JUNTA DE LICENCIAMIENTO Y DISCIPLINA MÉDICA DE PUERTO RICO

Nombre del examinado_____

Lugar donde se realizó el examen médico_____

Nombre y número de licencia del médico que realizó el examen_____
_____

CERTIFICACION MÉDICA SOBRE CONDICIÓN FÍSICA Y MENTAL
PARA EJERCER LA PROFESION MÉDICA EN PUERTO RICO

Yo,_____ , con Licencia número _____ la cual se encuentra vigente expedida por la Junta de Licenciamiento y Disciplina Médica de Puerto Rico para ejercer la medicina, acredito y certifico que, _____ ha sido examinado por mi persona y

( ) Tiene la capacidad y competencia física mental para ejercer la profesión médica en Puerto Rico.

( ) No tiene la capacidad y competencia física y mental para ejercer la profesión médica en Puerto Rico.

Acreditado y certificado hoy ___de _____ de 20____ en_____ de Puerto Rico,

_____
Firma del médico licenciado

Advertencia: La Certificación debe estar cumplimentada en su totalidad

JUNTA DE LICENCIAMIENTO Y DISCIPLINA MEDICA DE PUERTO RICO
PO BOX 13969, SAN JUAN, PR 00908-3969
(787)765-2929

aprob. oct 2018

(Rev. December 2018 smn)