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

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

APPLICATION FOR LICENSURE TO PRACTICE PHYSICIAN ASSISTANT 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 to obtain a license to practice Physician Assistant 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 Act. No. 71-2017, that regulate the Practice of the Physician Assistants in Puerto Rico, and the Regulation containing the information and rules governing the practice of Physician Assistant in Puerto Rico? Yes ____No_____

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

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 attended _____

_____

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)**

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 for a license to practice as a Physician Assistant 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 for a license to practice as a Physician Assistant in Puerto Rico pursuant to Law.

_____ _____
Physician's Name Physician's Signature

Address _____

_____Phone #_____License#_____