



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 been 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 not 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 illegally? 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 _____ 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 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 _____

on the _____ day of _____ de _____ College or University

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# _____