APPLICATION FOR POSTGRADUATE TRAINING PROGRAM

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FOR SAN JUAN CITY HOSPITAL GRADUATE MEDICAL EDUCATION
OFFICIAL USE ONLY
(Please leave this section in blank)

DATE RECEIVED : _____

RECEIVED BY : _____

SIGNATURE : _____

VIA : __ Mail __ Personal __ E - Mail

__ Transitional Year Program
__ Internal Medicine
__ Pediatrics
__ Obstetrics & Gynecology

_____
Signature

I hereby apply for Postgraduate Training Program _____
(Specify program and training level)

at the San Juan City Hospital to start on _____
(month, day, and year)

I. PERSONAL DATA:

Name _____ Age _____ Sex _____

Social security number _____Birth date_____
(month, day, and year)

Birthplace _____Marital status_____

Dependents number _____ U.S. Citizen ____ YES ____ NO

If NO, Please give Country of Citizenship _____

Visa number _____
(Accepted by ACGME only. If not, leave the space in blank)

Current address _____

_____ Telephone (____) _____

Postal address _____

_____ Telephone (____) _____

Name and address of person that can contact you if needed _____

_____ Telephone (____) _____

If foreign medical school graduate, ECFMG certificate number_____

Year ECFMG certification _____

Puerto Rico License or temporary certificate number _____

Do you speak the spanish language fluently? ___ YES ___ NO

Military status (give dates and types of service) _____

_____

Are you a participant in the National Intern Matching Program? ____ YES ____ NO

II. EDUCATION : (Include all academic and professional education beyond: College, Medical School, internship, residencies technical training; enumerate in chronological order, for Postgraduate

Medical Education please give address and telephone numbers of Hospitals and Department Directors for proper verification of information)

EDUCATION	NAME OF INSTITUTION – SCHOOL AND OR DEPARTMENT LOCATION (Please include postal address)	DEGREE	MONTH AND YEAR ATTENDED	
			FROM	TO

III. RELEVANT WORK EXPERIENCE

NAME AND LOCATION OF EMPLOYER (Please include postal address)	POSITION TITLE	MONTH AND YEAR	
		FROM	TO

IV. ADDITIONAL INFORMATION OR SPECIAL QUALIFICATIONS SUCH AS MEMBERSHIP IN MEDICAL SOCIETIES, PUBLICATIONS, ETC.

_____

_____

V. HEALTH

Do you have or have had any illness or physical disability that might in any way interfere with the proper performance of your duties? ____ YES ____ NO. If Yes, explain_____

_____

VI. LIST BELOW THE NAMES OF THE DEAN OF YOUR MEDICAL SCHOOL AND TWO ADDITIONAL PHYSICIANS WHO HAVE SUPERVISED YOU DURING ROTATIONS. ASK THEM TO WRITE DIRECTLY TO US A RECOMMENDATION LETTER ON YOUR BEHALF.

1. Name _____

   Address _____

2. Name _____

   Address _____

3. Name _____

   Address_____

VII. PLEASE ENCLOSE PROPER DOCUMENTATION TO:

LUIS A. MEDINA, MD
DIRECTOR OF GRADUATE MEDICAL EDUCATION
SAN JUAN CITY HOSPITAL
PMB # 79 P.O. BOX 70344
SAN JUAN, PUERTO RICO 00936-8344