RESIDENCIA DE MEDICINA DE FAMILIA MANATÍ MEDICAL CENTER

Manatí Medical Center

APLICATION FOR RESIDENCIY TRAINING

Appointment to begin: July 1st, _______

1. Name: _________________________________
2. Physical Address:

   ____

   ____

3. Postal Address:

   ____

   ____

4. Telephone: (___)___________ Home (___)___________ Work

   (___)___________ Cel. Email:_______________________

5. Birth Date: ___/_____/______ Place of birth ______________________

   S.S. _____/_____/______

6. Name of Spouse: ________________________ Phone: (____)_____________
7. Do you speak and write Spanish? _______ speak _______ write
8. Do you speak and write English? _______ speak _______ write
9. Pre-medical Education: ____

   Completion Date: ________________________ Degree:_______________________

10. Medical School: ____

    Completion Date: ________________________

11. Post-Graduate Education (Internship): ____

    Completion Date: ________________________

12. Puerto Rico Board of Medical Examiners:

    Part I ________ Part II ________ Part III______

    Date ___/____/____ Date ___/____/____ Date ___/____/____

13. USMLE Exam:

    Part I ______ Date ___/____/____

    Part II CK _______ Date ___/____/____ CS _______ Date ___/____/____

    Part III ________ Date ___/____/____

14. ECFMG Certification: Yes_____ No______

    Certification # ____________________________ Date ___/____/____

15. Puerto Rico Permanent License: _______________

16. Previous Work Experience (If more than three (3) use back of sheet):

Position	**Supervisor**	**Address / Telephone**
______________________	___________________________	___________________________
______________________	___________________________	___________________________
______________________	___________________________	___________________________

17. Other References:

____

____

18. Research / Publications:

____

____

19. Questions:

a. Do you have any commitment with the Armed Forces?

_____ Yes _____ No Specify: ____________________________

b. Are you participating in the National Intern Matching Program?

_____ Yes _____ No Specify: ____________________________

c. Do you have any commitment with the National Health Service Corps?

_____ Yes _____ No Specify: ____________________________

d. Do you have or ever had any physical or mental impairment that could interfere with your performance as a doctor?

_____ Yes _____ No Specify: ____________________________

e. Have you ever been convicted of a felony?

_____ Yes _____ No Specify: ____________________________

f. Have you applied to any other programs?

_____ Yes _____ No Specify: ____________________________

SIGNATURE: __________________________________

DATE: ____________________________

/nms

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