Mayagüez Medical Center
Dr. Ramón Emeterio Betances
Ponce Health Science University Consortium
Graduate Medical Education Office
410 Hostos Avenue
Mayagüez, PR 00680

REQUIREMENTS FOR ADMISSION TO FELLOW PROGRAM:

1. **Complete Application Form**
2. **Copy Transcripts of Premedical Education**
3. **Copy Transcripts of Medical Education**
4. **Diploma of University/School Graduate Medicine**
5. **Diploma of Internship – if applies**
6. **Diploma or Certificate from Internal Medicine Residency – if applies**
7. **ABIM Certificate – if applies**
8. **Copy Document Dean Letter's / School Graduate (MSPE)**
9. **Copy Certified Transcripts Score (USMLE)**
10. **If foreign graduate: ECFMG**
11. **If you have Puerto Rico Board of Licence and Medical Disciplines**
12. **Recent Certificate of No Penal Record**
13. **Curriculum Vitae actualized to the current year**
14. **Personal Statement**
15. **(2) Letters of recommendation actualized to current year (one letter of recommendation of a Cardiology Physician)**
16. **One (1) recently photo 2x2**
17. **Fluency in both: Spanish and English Language**
18. **Evidence of all vaccines administered including: Hepatitis, Chicken Pox, Influenza & COVID-19**
19. **ID with photo or passport / S.S.**
20. **Certificate of Health Insurance Plan**
21. **Recent Negative ASUME Certificate**
22. **BLS & ACLS Certificate**

All documents should be sent via email:

mmc-cvdfellow@mayaguezmedical.com

Mayagüez Medical Center
Dr. Ramón Emeterio Betances

Graduate Medical Education
Cardiovascular Diseases Fellowship Program Application

Attached Recent Photograph

Photo 2 x 2

1. Name (Last –Paternal – Maternal) (First) (Middle) _____

2. Social Security Number _____

[ ] Cardiovascular Diseases Fellowship _____ Level _____
Start Date

3. Permanent Address (Street)

4. Phone Number (Cellular)
( ) -

5. Mailing Address (Street)

_____ _____ _____
(City) **(State)** **(Zip)**

6. I identify my gender as:
❑ Man ❑ Woman ❑ Genderqueer/Non-Binary
❑ _____ (fill in the blank)
❑ Prefer not to disclose

7. Citizenship: [ ] US

[ ] other: _____

8. Name of person through whom I can always be contacted

_____
(Name of Person)

_____
(phone)

9. Civil Status

[ ] married [ ] single

10. Date of Birth

(month/ day/ year) _____ / _____ / _____

11. E-mail address:

12. Birth Place: _____

UNDERGRADUATE EDUCATION

13. University (s) (**Name)**

(City) (**State)**

14. Month / Admission to University **16. Month / Year of (anticipated) Graduation**

15. Honors/ Awards

GRADUATE EDUCATION

16. Medical School **Dates Attended** **Graduate Degree** **Area of Study**

From _____ To _____ **(If any)**

a. Name

(City) **(State)**

INTERNSHIP OR RESIDENCY PROGRAM

17. a. Name

(City) **(State)** **(Year) From: _____ To _____**

b. Name

(**City)** **(State)** **(Year) From: _____ _____**

RELEVANT WORK EXPERIENCE

18. Name and Location of Employer: _____

Position _____

Month and Year: _____

19. Additional information or special qualification such as membership in medical societies, publications, ect.

_____

_____

LICENSURE STATUS

20. I am planning to take or have already passed the examination checked below; please, write the score obtained.

[ ] PUERTO RICO MEDICAL BOARD

I. _____ _____
(Score) (Date)

II._____ _____
(Score) (Date)

III._____ _____
(Score) (Date)

Permanent License Number: _____

[ ] USMLE/ NATIONAL BOARD: STEP I. _____/_____ STEP 2 CK _____/_____
Score Minimum Pass Score Minimum Pass

OET_____ STEP 3 _____/_____
Test Result Score Minimum Pass

_____

[ ] ECFMG Certificate Number: [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] - [ ]

_____

OTHER INFORMATION

_____

21. Do you have any commitment with the Armed Forces [ ] yes [ ] no

Specify: _____

_____

22. Are you participating in the National Matching Program? [ ] yes [ ] no

23. Have you ever been involved in, or pending, any malpractice actions?
Specify: _____

_____

24. Do you have or have had any physical or mental illness that in any way interfere with the proper performance of your duties as a physician? [ ] yes [ ] no
Specify: _____
_____

25. Have you been convicted for any felony charges? [ ] yes [ ] no
Specify: _____
_____

26. References; list below the name and address of your references and ask them to write a letter directly to the Director of Graduate Medical Education with copy to the Director of the Residency Program. The reference should be physicians who have supervised you direct.

a. (Name)	**b. (Name)**
Address: (Street)	**Address: (Street)**
(City) (Street) (Zip)	**(City) (Street) (Zip)**

INSTRUCTIONS

1. **Enclose copy diplomas, and certified transcripts of Premedical and Medical Education.**
2. **If graduate from foreign University or Hospital, documents must be legalized.**
3. **Submit one original and one copy of this application.**

I certify that all the information is correct and authorize to consult or request information about it.

Signature of applicant: _____ Date: _____

DO NOT WRITE BELOW THIS LINE: FOR MEDICAL EDUCATION OFFICE USE ONLY.

Action taken by Admission Committee:

[ ] Admitted [ ] Not admitted [ ] Alternate