



Formulario de Solicitud de Examen de Reválida

Favor de llenar en su totalidad en letra de molde

Información Personal

Primer Apellido Segundo Apellido Primer Nombre Inicial

Seguro Social
*Últimos 4 dígitos

Fecha de Nacimiento
dd/mm/yyyy

F ☐

M ☐

Ciudadanía: _____

Teléfono Celular

Teléfono Hogar

Teléfono Trabajo

e-mail Ejemplo: user@yahoo.com

Información de Contacto
Dirección Postal

Examen:

☐ LEGISLACION FARMACEUTICA

País, Ciudad, Código Postal

Número de Intento: _____

Institución de Procedencia: _____

Para uso de la ORCPS: Certificado Permanente: _____ Fecha: _____

Visto Bueno: _____



APPLICATION FOR EXAMINATION

Name: _____

Physical Address: _____

Postal Address: _____

Telephone: Work _____ Residence _____ Cellular _____

Social Security Num. _____ Date of Birth _____

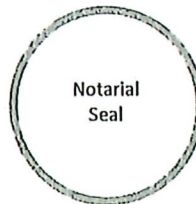
ADHIERA FOTOGRAFIA
RECIENTE,
AUTOGRAFIADA
TAMAÑO PASAPORTE

AFFIDAVIT

State _____ or _____ of _____ (territory)
_____ country of (or
city) _____
says that _____ he
(her) is the person referred to in this application and that
the statements herein contained are true in every respect,
and that the attached photograph is a true likeness of her
(him) self taken within the last six months.

SUBSCRIBED AND SWORN TO BEFORE ME this _____ day of _____
20____. Witness my hand and seal hereunto attached.

AFFIDAVIT NUM.: _____



Signature of Notary Public



PERSONAL INFORMATION OF THE APPLICANT

1. Has your name ever been changed? Yes _____ No _____
If so, give date and place of such change _____
Give the original name _____
2. Place of birth _____ Age: _____
3. Are you a citizen of the United States? Yes _____ No _____ (If naturalized, give date and place of naturalization _____)
4. Have you ever practiced pharmacy illegally? Yes _____ No _____
5. Have you ever been convicted of, or indicted for any crime? Yes _____ No _____ If so, state facts in the case here or on separate sheet and attach _____
6. Do you suffer of any physical or mental condition? Yes _____ No _____ (If yes, please submit a Doctor's Certification than explain your condition at the same date of this application).
7. Do you need special accommodation? Yes _____ No _____ (If yes, please present evidence for this petition).

HIGH SCHOOL EDUCATION

I was graduated from the _____

High School, located at _____, Puerto Rico, on the _____ day of _____, 20____

COLLEGE OR UNIVERSITY EDUCATION

Name and location of institution attended

Period of attendace (for example, October 1993 to May 1994)

1st year _____
2nd year _____
3rd year _____
4th year _____

I have credit for _____ of college work. I received the degree of _____ from _____ on the day of _____.



I attended _____ full courses (credits) Pharmacy lectures as follows:

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

At _____
from the _____ day of _____, 20____
to the _____ day of _____, 20____

I was granted a Diploma of Doctor of Pharmacy by _____
located at _____ state of _____
On the _____ day of _____, 20____

The following documents are considered part of this application

- Official application for examination duly fulfilled
- Original and copy of the College of Pharmacy Diploma
- Official transcript of subjects and grades in pharmacy, must be requested from the College of Pharmacy to be sent directly to the Board of Pharmacy of Puerto Rico, at the following address:

**Office of Regulations and Certification of Health Professionals
P.O. Box 10200
San Juan, Puerto Rico 00908-0200**

- Certification issued by the register of the university where you obtained your degree of Bachelor in Pharmaceutical Sciences, showing that you completed such degree and the date of graduation.
- Birth Certificate (Original and copy)
- Certificate of Penal Record, issued by the Department of Police (Original)
- Health Certificate – From a Public Hospital or Private Physician
- Postal Money Order or Certified Check payable to the Secretary of Treasure of Puerto Rico on the amount of \$200.00 or ATH, VISA or MASTERDARD (local examination).
- Only the Puerto Rico University and the universities recognized by the American Council on Pharmaceutical Education are approved by this Board.
- All information requested in this application must be submitted.
- Postal Money Order or Certified Check payable to **Didaxis** on the amount of \$75.00. You can also pay by ATH, VISA or MASTERCARD. CASH OR PERSONAL CHECKS IS NOT ACCEPTED. Payment centers are the following:

Didaxis Centro Metro, Club Rotario de Río Piedras, Urb. Caribe, 1609 Calle Ponce de León
Carr. Núm. 1 de Río Piedras, P.R. 00928. Tel. (787) 223-1133. www.didaxispr.com.

- Criminal Record Certificate (ORIGINAL) issued by the Puerto Rico Police with no more than one (1) months prior to the requested test.
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National Association of Board of Pharmacy Licensure Examination (Naplex)

- Postal Money Order or Certified Check payable to the Secretary of Treasure of Puerto Rico on the amount of \$500.00.

NOT BE ACCEPTED INCOMPLETE APPLICATIONS OR AFTER THE DATE LIMIT