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| **APPLICATION FOR RENEWAL OF REGISTRATION OF MEDICAL** |
| i. Identification Data |
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| 1. Social Security Number: * -
 | 2. Medical license | 3. Date of birth AAAA MM DD | 4. Gender❑ Male❑ Female |
| 5. Federal Narcotics License Number | 6. State Narcotics License Number | 7. Marital Status |
| 8. Birth Name  |
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| Paternal Surname | Maternal Surname | Name  | Initial |
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| 9. Have you ever changed your name because of marriage or legal case? ❑ Yes ❑ No 10. If the previous answer was yes, please enter your current name. |
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| Paternal Surname | Maternal Surname | Name  | Initial |
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| 11. Place of Birth  |  | 12. You Are a U.S. Citizen? ❑ Yes ❑ No |
|  | City or Town |  | State or Country |
| 13. Visa Number or Certification of Naturalization:  |
| 14. Physical Address | 15. Postal Address |
|  |  |
| Neighborhood or Development | Neighborhood or Development |
|  |  |
| Street and Number or PO Box | Street and Number or PO Box |
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| City or Town | State or Country | Zip Code | City or Town | State or Country | Zip Code |
| 16. Email | 17. NPI Number |
|  |
| 18. Work Phone | Home Phone | 20. Cell Phone |
| PP | PP | PP |
| 21. License Type | 22. Date of issue of your license |
| 23. Place where you practice your profession: | City or Town: | State or Country:  |
| 24. Another place where he practices his profession: | City or Town: | State or Country:  |
| 25. Place of Residence: | City or Town: | State or Country:  |
| II. Academic Preparation |
|  |
| 26. Year of Graduation:  | 27. Highest grade you possess: |
| 28. Institution where you graduated from your profession |  |  |
|  | City or State | Institution |
| 29. Indicate the specialty and institution from which you graduated. |
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| A. Speciality: |
|  Institution where he finished specialty: |
|  |  | Year that was certified by the JLDM |  |
| City or Town | State or Country | Dedicated practice hours |  |

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| B. Speciality: |
|  Institution where he finished specialty: |
|  |  | Year that was certified by the JLDM |  |
| City or Town | State or Country | Dedicated practice hours |  |

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| C. Speciality: |
|  Institution where he finished specialty: |
|  |  | Year that was certified by the JLDM |  |
| City or Town | State or Country | Dedicated practice hours |  |

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| 30. Indicate the sub-specialty and institution from which you graduated.

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| A. Sub-specialty: |
|  Institution where he finished sub-specialty: |
|  |  | Year that was certified by the JLDM |
| City or Town | State or Country | Dedicated practice hours |
| B. Sub-specialty: |
|  Institution where he finished sub-specialty: |
|  |  | Year that was certified by the JLDM |
| City or Town | State or Country | Dedicated practice hours |
| C. Sub-specialty: |
|  Institution where he finished sub-specialty: |
|  |  | Year that was certified by the JLDM |
| City or Town | State or Country | Dedicated practice hours |

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| 31. Practice Area: Acupuncture Certification ❑ Yes ❑ NoTelemedicine Certification ❑ Yes ❑ No |
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| III. Employment Status in the Profession |
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| 32. You are currently working (Active) in your profession or performing for one or more hours a week in related activities (teaching, research administration, etc.? (Mark with an X) |
| ❑ | 01. Yes, active in the profession in Puerto Rico. |
| ❑ | 02. Yes, active in the profession outside of Puerto Rico. |
| ❑ | 03. No, inactive at present. |
| 33.If you are not currently working in the profession, select the alternative that best describes your employment status. |
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| ❑ | 01. Working in another field, but searching for work in my profession. | ❑ | 08.Studying or training in the same profession full-time.Indicate: |
| ❑ | 02. Working in another field, but not searching for work in my profession. | ❑ | 09. Studying or training in the same profession on a part-time basis.Indicate: |
| ❑ | 03. Unemployed, but searching for work in my profession. | ❑ | 10. Studying or training for another profession full-time.Indicate: |
| ❑ | 04. Unemployed, but searching for work in another field. | ❑ | 11. Studying or training for another profession part-time.Indicate: |
| ❑ | 05. Unemployed, but searching for work. | ❑ | 12. Research. |
| ❑ | 06. Retired or incapacitated | ❑ | 13.Other  |
| ❑ | 07. Housewife. | If I answer alternatives 8,9,10 or 11, please indicate the year you expect to finish.  |

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| III. Employment Status in the Profession (cont.) |
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| 34. What was the last year you worked in the profession or related activities? (Do not include years of residency or internship**)** |
|  Year  | ❑ I have never worked in my profession (Mark with X) |
| 35. Number of years you have worked in your profession. (Do not consider years with periods of inactivity of more than 6 continuous months as a working year) |
| Number of Years  | ❑ I have never worked in my profession. (Mark with X)**Note: If you are inactive in the profession, go to question 40** |
| 36. **Main sector of work** to which he devotes most of his time in the practice of his profession. Note: Select your primary sector of work. If you work or practice in more than one sector, write in the space provided a 1 in the sector where you work the longest and a 2 in the other sector of work. If you have two jobs in the same sector, write a 1 and 2 in the same space. (Do not select more than two sectors and do nor mark with X)

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| ❑ | 1. Public sector | ❑ | 4. Private sector (Does not include own employment. Refers to whether you are employed by an institution or other professional.) |
| ❑ | 2. Individual Private Practice | ❑ | 5. Voluntary work |
| ❑ | 3. Private group or Partnership Practice |  |  |
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| 37**. Institution where you work most of the time.****Note:** Select the working sector and the type of institution in which you work most of the time. Type 1 in the appropriate space. If you work in more than one type of institution, select this second institution, and write a 2 in the corresponding space. If you have two jobs in the same institution, write a 1 and 2 in the same space. (Do not select more than two institutions. Do not place an “X”) |
| **Public Institution** | **Private Institution** |
| ❑ | 01. Public Hospital (Includes Public Corporation and Health Center) | ❑ | 01. Private Hospital, Inpatient Clinic |
| ❑ | 02. Federal Government Facilities | ❑ | 02. Private Office |
| ❑ | 03. Public Health Unit or Subunit | ❑ | 03. Private Laboratory |
| ❑ | 08. 04. Family Health Center, Diagnostic and Treatment Center (Dispensary) | ❑ | 04. Dispensary, Polyclinic, Private Diagnostic Center |
| ❑ | 05. Health House | ❑ | 05. Private Home Health Care Service |
| ❑ | 06. Mental Health Center, Psychosocial Rehabilitation Center, Institution for Alcoholics and Drug Addicts | ❑ | 06. Health House |
| ❑ | 07. Geriatric Center | ❑ |  07. Pediatric Autism Center |
| ❑ | 08. Pediatric Autism Center | ❑ |  08. Health Insurance Company |
| ❑ | 09. Armed Forces | ❑ |  09. Institution for the Elderly, Children and the Disabled |
| ❑ | 10. State or Municipal Government Agency | ❑ |  10. Scientific Research Institution |
| ❑ | 11. Vocational Rehabilitation Center | ❑ |  11. Commerce, Manufacturing and/or Industry |
| ❑ | 12. Other   Specify the Name | ❑ |  12. Health Services in Private Educational Institutions |
|  |   | ❑ |  13. Professional Association or Non-Profit Entity |
|  |  | ❑ | 14. Other   Specify the Name |
| **Academic Institution** |
| ❑ | 01. School or College of Medicine or Dentistry  | ❑ | 02. Other Schools or Colleges  |
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| **III. Employment Status in the profession (cont.)** |
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| 38. Institution in which he works most of the time. (According to the answer to question 37 between workplace addresses |
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| Address of the Main Workplace | Secondary Workplace Address |
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| Neighborhood or Urbanization | Neighborhood or Urbanization |
|  |  |
| Street and Number or PO Box | Street and Number or PO Box  |
|  |  |  |  |  |  |
| City or Town | State or Country | Zip Code | City or Town | State or Country | Zip Code |

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| 39. How many **hours per week** do you devote to the following activities in the practice of the profession or in related activities? Determine the activities that apply to you according to the type of work you do in the profession. Type the times in the space on the left. |
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| **Hours** | **Activities** |
|  | a Providing direct care to patients. |
|  | b. Providing guidance or services to patients and/or community. |
|  | c. Advice to other physicians and/or agencies and institutions. |
|  | d. Trade, manufacturing, or industry. |
|  | e. Teaching (refers to you working as a teacher at an educational institution). |
|  | f. Training (Includes time spend as a continuing education or in-services training resource). |
|  | g. Administration, Supervision and/or Coordination. |
|  | h. Investigación. |
|  | i Other  Specify |
|  | **Total Hours** |

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| **III. Overview** |
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| 40. a. You have practiced your profession illegally in Puerto Rico or in some other state or country?❑ Yes ❑ No    Country City41. He has been charged with a crime or convicted of some crime in Puerto Rico or in some state or other country? ❑ Yes ❑ No  Country City |

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| 42. Have you been under medical treatment for having depended on or used drugs or alcohol in Puerto Rico or any other state or country? ❑ Yes ❑ No    Country City |

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| 43. You have been charged, convicted, or convicted (plea of guilty) for illegally practicing your profession or any specialty or profession not certified by the Boards, in Puerto Rico or in any state or in any other country? ❑ Yes ❑ No   Country City |

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| 44. Since your last license registration, have you been sued for professional malpractice in Puerto Rico or in any state or other country? ❑ Yes ❑ No    Country City45. Since your last license registration, have you received a judgment or filed a claim for professional malpractice in Puerto Rico or in any state or in any other country? ❑ Yes ❑ No    Country City |

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| 46. You have been arrested, charged, imprisoned or placed on probation for any case filed against you for any violation of law, regulation or ordinance in Puerto Rico or in any state or in any other country? ❑ Yes ❑ No     Country City47. You have another license in another state or country? ❑ Yes ❑ No   Country City |

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| 48. Your license has been restricted, limited, conditioned, sanctioned, suspended, canceled or revoked in Puerto Rico or in any state or in any other country? ❑ Yes ❑ No     Country City49. Regularly use controlled substances, alcohol, or have a mental illness?  ❑ Yes ❑ No    |

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|  50. Has advertised or practiced as a specialist or sub-specialist without being properly certified by the Medical Licensing and Discipline Board to do so? ❑ Yes ❑ No  51. You complied with notifying the Office of Regulation and Certification of Health Professionals and/or Medical Licensing and Discipline Board of all claims, judgments, transactions, or actions filed against you related to professional malpractice? ❑ Yes ❑ No   |

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| 52. Your narcotics license has been denied, suspended, cancelled, revoked, surrendered or placed on probation in Puerto Rico or in any state or in any other country? ❑ Yes ❑ No    Country City1. You are willing and interested in offering community services related to your profession?

 ❑ Yes ❑ No    |

54.In case of an emergency, you want to volunteer in public health matters? ❑ Yes ❑ No55. Has a financial responsibility policy in accordance with section 41.050 of the Insurance Code of Puerto Rico, of Law No. 77 of June 19, 1957 as amended? ❑ Yes ❑ No  56. If you do not apply the previous question, indicate if you have financial protection through a trust. ❑ Yes ❑ No  57. **If the previous question was yes, include a simple copy of the deed.** |
| **V. Continuing Medical Education**  |
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| **The law establishes that the Physician-Surgeon will be re-certified every three years, always upon expiration of his current recertification, and based on continuing medical education.** **Sixty (60) hours of education are required for recertification over a period of three (3) years, of which a minimum of forty (40) hours will be in Category 1.** |
| **Please provide the information requested below. (Must include original certificates and copies of continuing education courses taken).** |
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| **VI. Certification, Right to Pay and Medical Oath** |
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| Included ❑ Money Order | Date:   Year MM DD |  Official receipt number |

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| I do solemnly certify and swear that the above information in this registration application is completed, true, and correct. In turn, I do authorize the JLDM to require me to submit to any mental, physical or chemical dependence examination and to relieve me and waive the right to make any objection to the admissibility of the result in any hearing before the JLDM. |
|   Year MM DD  **Date** | Signature |
| **For Official Use (Do not write in this space)** |
|  |
| Meets the requirements? ❑ Yes ❑ No  |
|  | Reason: |  |

**(Rev. 08/10/2023**