

PROFESSIONAL EXAMINATIONS			
EXAMINATION	DATE	SCORE	COMMENTS
MCAT			
USMLE Step 1			
Other			
How many times have you taken the USMLE Step 1?			
Have you applied to this School before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date:			
Honors received while in College (including Honorary Societies):			
Extracurricular and/or Community Activities:			
How have you spent your last five summers?			
If your education to date has not been continuous, indicate what you have done while not in medical school:			
Were you ever required to leave or have withdrawn from any college or school or were denied readmission for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Have you ever been the recipient of any action by any postsecondary institution for unacceptable academic performance such as dismissal, disqualification or suspension or for conducts violations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
FOR OUR STATISTICS:			
Please indicate the group that you most identify with: (Your response will be kept confidential and will provide data to the federal government in compliance with the Title IV of the Civil Rights Act of 1964):			
<input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian /Alaskan Native <input type="checkbox"/> Other			

PERSONAL COMMENTS: Use this section to include details of your application that needs further clarification. If necessary, you may use a separate sheet of paper and write **See Attached** below.

CERTIFICATION STATEMENT AND SIGNATURE

I hereby certify that all the information provided in this application is complete and accurate and I agree to comply with the rules and regulations of PSM and to cooperate in maintaining high standards of scholarship and conduct.

SIGNATURE

DATE

Ponce School of Medicine does not discriminate on the basis of race, sex, creed, national origin, age or handicap.



PONCE SCHOOL OF MEDICINE AND HEALTH SCIENCES

ADMISSIONS OFFICE

PO Box 7004 - Ponce, Puerto Rico 00732-7004

787-840-2575 Ext 2142 – 2143

www.psm.edu admissions@psm.edu

ADMISSION TO ADVANCED STANDING

(PLEASE KEEP THIS PAGE FOR YOUR RECORDS)

DOCUMENTS REQUIRED:

- Official transcript from all universities attended (in English)
- Official transcript from your medical school (in English or with English translation)
- Authorization for the Use of Medical School Official Transcript (form provided by the Admissions Office)
- Letter of academic standing from the Dean of your medical school
- Two (2) letters of recommendation from professors of your medical school
- Letter explaining your reasons for seeking transfer
- MCAT official scores (www.aamc.org/mcat)
- USMLE Step 1 official scores (www.ecfm.org)
- US\$100.00 non-refundable application processing fee (check or MO payable to Ponce School of Medicine and Health Sciences)
- Certificate of No Penal Record (Police Background or Record Check)

Please send to: Ponce School of Medicine and Health Sciences
 Admissions Office
 PO Box 7004
 Ponce PR 00732

Deadline for submitting a complete application: **MAY 15**

glc



PONCE SCHOOL OF MEDICINE AND HEALTH SCIENCES

ADMISSIONS OFFICE

PO Box 7004 - Ponce, Puerto Rico 00732-7004

787-840-2575 Ext 2142 - 2143

www.psm.edu admissions@psm.edu

Authorization for the Use of Medical School Official Transcript

Instructions to the Student: Please fill out this authorization and send it to your School of Medicine.

I, _____ STUDENT'S NAME _____ respectfully request authorization to use my official transcript from _____ MEDICAL SCHOOL NAME _____ for educational purposes, such as request for clinical electives, application for National Residency Matching Program (NRMP) and Electronic Residency Application System (ERAS). If you have any questions, please contact me at:

Student's Name _____ PLEASE PRINT _____

Address: _____

Telephone: _____ E-mail: _____

Signature Date

For the exclusive use of the student's School of Medicine:

I hereby authorize Ponce School of Medicine and Health Sciences to use the official transcript of _____ for educational purposes.
(Student's name)

Signature of Medical School Official Date

Print Name Position

Please send this document to: **Ponce School of Medicine and Health Sciences
Admissions Office
P.O. Box 7004
Ponce, PR 00732**