University of Puerto Rico: Mayagüez Campus
Dean of Students
Department of Medical Services

15th of January, 2025.

NEW ADMISSION STUDENTS, GRADUATE STUDENTS, READMISSION, TRANSFER WITHIN UPR SYSTEM, TRANFER FROM EXTERNAL UNIVERSITY, INTERNATIONAL AND EXCHANGE STUDENTS, SPECIAL PERMIT AND PROFESSIONAL DEVELOPMENT FOR FALL SEMESTER 2025-2026.

Welcome to the "*Antes, Ahora y Siempre,* ***COLEGIO***." We would like to inform you that you must comply with the Certification 23-24-145 issued by the Administrative Board of the University of Puerto Rico. This Certification states that all admitted students must turn in a series of documents to the Department of Medical Services before confirming tuition for August 2025.

The required documents will vary according to the classification for which you were admitted to. The documents and a form with a list of documents according to admission classification will be attached for reference. You must complete the documents in their entirety (please write N/A if a question is not applicable to you.), identify all documents with your name, last names, and assigned student number. These documents must be uploaded in pdf format to the UPR online portal (**https://portal.upr.edu),** accessing the "Medical Documents" icon and submitted in the corresponding order presented. Each document must be uploaded individually. The due date for submitting these documents is **Tuesday, June 10th, 2025**.

Upon entering the Medical Documents icon, you must complete the Health Insurance Selection Form with the corresponding information for the semester. Afterwards submit the remaining required documents in the "Documents" tab. ***Documents sent through email will not be accepted.***

The following three (3) documents must be turned in personally or by postal mail as their original copies to the Department of Medical Services in addition to the online portal.

1. Original Vaccine Certification (PVAC -3)
2. Copy of COVID Vaccine Certification issued by the Department of Health of Puerto Rico.
3. Original Sworn Affidavit (if younger than 21 years old) or Consent Form for Medical Evaluation and Treatment (if 21 years old or older) as applicable to your age.

Mailing Address: **Universidad de Puerto Rico Recinto de Mayagüez,**
Departamento de Servicios Médicos
Call Box 9000
Mayagüez P. R. 00681- 9000.

For more information please visit our website at https://www.uprm.edu/serviciosmédicos/ or call (787) 832-4040, ext. 3408 / 3416 (M-F de 8:00am -4:00pm).

We wish you the greatest success in your university career and we are at your service.

Cordially,

Sra. Edna E. Acevedo Castro
Interim Director DSM UPRM

El Departamento de Servicios Médicos Cuidando tu Salud… SIEMPRE

UNIVERSITY OF PUERTO RICO
MAYAGUEZ CAMPUS
DEPARTMENT OF MEDICAL SERVICES

LIST OF DOCUMENTS TO TURN IN, ACCORDING TO CLASSIFICATION IN portal.upr.edu
(Certification #24-25-087, Management Board RUM, 9 of December of 2024)

1.New Admission, Readmission, Transfer UPR System and External University Transfer Students

- Medical History
- Tuberculin Test and/or Chest X-Ray Reading (Less than 1 year)
- Vaccination Certificate P-VAC-3 (Original) up to date, including Covid-19 Vaccine evidence
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old)
- Privacy Policy Notification (HIPAA Law)
- 2 x 2 Profile Photo

2.Graduate Studies Students

A. From another university or did not study the semester previous to graduate school admission.

- Medical History.
- Tuberculin Test and/or Chest X-Ray Reading (Less than 1 year).
- Up-to-date Vaccination Certificate or up-to-date TD Vaccine. Covid-19 Vaccine Evidence.
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old).
- Privacy Policy Notification (HIPAA Law).
- 2 x 2 Profile Photo.

B. Graduates from RUM the previous semester.

- TD Vaccine Booster, if administered more than 10 years ago. Evidencia de Vacunas Covid-19.
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old).
- Privacy Policy Notification (HIPAA Law).
- 2 x 2 Profile Photo.

3.International and Exchange Students

- Medical History.
- Medical Exam.
- Tuberculin Test and/or Chest X-Ray Reading (Less than 1 year).
- VDRL/RPR (Serology) (Less than 6 months).
- Hepatitis B Blood Test (Less than 6 months).
- Up-to-date Vaccination Certificate or up-to-date TD Vaccine. Covid-19 Vaccine Evidence.
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old).
- Privacy Policy Notification (HIPAA Law).
- 2 x 2 Profile Photo.

4.Transient and Special Permit Students

- Medical History.
- Vaccination Certificate P-VAC-3 (Original) up to date, including Covid-19 Vaccine evidence.
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old).
- Privacy Policy Notification (HIPAA Law).
- 2 x 2 Profile Photo.

5.Professional Development and Teacher Certification Students

- Medical History.
- TD Vaccine Booster, if administered more than 10 years ago. Covid-19 Vaccine Evidence.
- Notarized Sworn Affidavit (for students younger than 21 years old) or Evaluation Consent (older than 21 years old).
- Privacy Policy Notification (HIPAA Law).
- Health Insurance Selection in the "Health Insurance" tab in Medical Documents of portal.upr.edu, or complete the Health Insurance Selection Form.
  *This classification **cannot** subscribe to the UPR Student Health Plan.
- 2 x 2 Profile Photo.

HEALTH INSURANCE: Complete "HEALTH INSURANCE" tab accordingly.

University of Puerto Rico: Mayagüez Campus
Dean of Students
Department of Medical Services

1 photo
2x2

( ) New Admission Student proceeding from Highschool
( ) Readmission
( ) Transfer from External University
( ) Graduate Student
( ) Transfer within UPR System
( ) Special Permit
( ) Professional Development
( ) International / Exchange Student

Medical History Part A: Demographic Information (TO BE COMPLETED BY THE STUDENT)

Full Name: _____ Student Number: _____ ____ _____	
Civil Status: Single_____Married_____Widowed___Divorced_____ Social Security Num.: _____ ___ _____	
Sex: ___M ___F ___Prefer not to answer	Age:_____Date of Birth :___/__/_____Place of birth: _____ DD MM YYYY
Father's Name: _____ Tel:_____ (Please include, even if not living together)	Mother's Name: _____ Tel: _____ (Please include, even if not living together)
Home address:	Mailing address:
Home phone number ( )_____- _____	Cellphone number : ( )_____-_____
Emergency Contacts: (Must include two adult family members who can legally make decisions for you) 1. _____Relation_____Tel. ( )_____-_____ 2. _____Relation_____Tel. ( )_____-_____	
Emancipated: No___Yes___(*present copy of legal evidence)	
UPRM email: _____Private Email:_____	

Part B: Mark with an X the illnesses and conditions you present or have presented.

	Anemia		Hepatitis		Psychiatric Illness		Other:
	Chickenpox		High Cholesterol		Respiratory Disease		
	Chronic Intestinal Problems		Hypoglycemia		Rheumatoid Arthritis		
	Diabetes		Kidney Disease		Rheumatic Fever		
	Diphtheria		Malignancy (Cancer)		Scarlet Fever		
	Emotional Alterations		Measles		Severe Traumas		
	Epilepsy		Mononucleosis		Sexually Transmitted Diseases		
	Frequent Cathartics		Mumps		Skin illness		
	Frequent Throat Infections		Orthopedic Problems		Speech Impediment		
	Hearing Impediment		Osteoporosis		Thyroid Diseases		
	Heart Problems		Otitis Media		Tuberculosis		
	Hemophilia		Poliomyelitis		Ulcers		

Hospitalizations or Illness within the last year: _____
Medication or Food Allergies: _____
Other Health Problems: _____
Ongoing Medical Treatment, if applicable: _____
Surgeries or Procedures: _____

**** The forms for students below 21 years old that are emancipated or with a legal tutor signature must be accompanied by the corresponding evidence of emancipation or assignment as legal tutor.***

_____ _____ _____ _____
Date **Student Signature** Date **Parent or Legal Tutor Signature**

Medical Form Part B (MUST BE COMPLETED BY A MEDICAL DOCTOR)

PATIENT'S NAME: _____ STUDENT NUMBER: _____

Important Requirements that must be included with this physical exam.

1. Tuberculin Test Results or Chest X-ray Reading Results (the x-ray reading results are requires in case of a positive Tuberculin test). Student athletes are required to turn in both.
2. Results of VDRL and Hepatitis B blood test.
3. Up to date P-Vac-3.

Weight: _____ Height: _____ Blood Pressure:_____ ___

Pulse: _____

Mark each corresponding column accordingly. Write N/E if it is not evaluated.

Clinical evaluation by system	Normal		Comments
	Yes	No	
Skin			
Ears, nose, throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Urogenital			
Musculoskeletal			
Neurological			
Hearing			

Lab Results: (*Must include lab reports)*

Tuberculin*	Date Administered:	Date of Reading:	Result:
Chest X-ray	Date Realized:	Result:	
VDRL	Date Realized:	Result:	
Hepatitis B	Date Realized:	Result:	

Note: If tuberculin test is positive a chest x-ray reading is required and evidence of treatment if necessary.

Brief of findings in medical history, physical exam, and required documents.

Questions (Medical History)	Yes	No	Include comment in case of "Yes"
Does the student have any significant or incapacitating health problem?			
Is the student receiving treatment for any physical or mental health condition?			
Is there any contraindication to the student's participation in athletic activities that require physical exertion?			
Is there any special recommendation for the management of the student's health problems during his stay in the UPRM?			

_____ _____ _____ _____ _____

Date of exam | Name of Doctor | Doctor's Signature | Lic. Num. | Tel.

University of Puerto Rico: Mayagüez Campus
Dean of Students
Department of Medical Services

SWORN AFFIDAVIT

PERSONAL INFORMATION, PATIENT UNDER 21 YEARS OLD

Full name: _____ Student Num.: _____

Date of birth (DD/MM/YYYY): _____ Age: ___ Tel.: _____

Civil status: _____ Spouse full name: _____ ☐ Not applicable

Information of father, mother, or legal tutor that fills out this document:

Full name: _____ Tel.: _____ Relation: _____

CONSENT FORM TO RECEIVE EVALUATION, DIAGNOSTIC, AND AMBULATORY TREATMENT

_____ _____
Patient name Father, mother, or legal tutor name

We authorize the personnel at the Departments and Offices of Medical Services of the campuses of the University of Puerto Rico, so that when the person designated here as patient solicits medical services the patient will receive the evaluations, diagnostic studies, non-urgent medical treatments, and in case of medical emergencies, will receive the medical treatment necessary based on clinical judgement within the usual practice and prevalent within medicine. We acknowledge that the practice of medicine is not an exact science and that we are not being offered a guarantee about the results of the services received.

In case of requiring medical services outside of the Departments or Offices of Medical Services, we authorize for the patient to receive the evaluations, diagnostic studies, emergency services, and non-urgent treatments, according to the patient's state of health. In which we authorize the patient to be accompanied by a representative of the university institution.

This authorization will be valid from the date of signature and while the student is studying in any of our campuses.

I certify that i have read and understand this consent form to receive health services, and that all the information provided is true and voluntarily given.

_____ _____
Patient name Father, mother, or legal tutor name

_____ _____
Date (dd/mm/yyyy) Time

*Required for patients under 21 years old, not emancipated. The forms for patients under 21 years old who are emancipated or with a signature from a legal tutor must be accompanied by the accrediting evidence of emancipation or designation as legal tutor, which must be stamped in case of being issued outside of Puerto Rico.

Affidavit number: _____

Sworn and signed before me by _____ and _____, of legal age, and

legal residence in _____,_____ and _____ (relation) to the patient in question,
City State/Country
and to whom I witness to have identified via _____(ID/Passport Number).

Signed in _____, _____, today ____ of _____ of 20___.
City State/Country

NOTARY SEAL AND SIGNATURE

PRIVACY POLICY NOTIFICATION

THIS NOTIFICATION DESCRIBES A BRIEF OS HOW YOUR HEALTH INFORMATION MIGHT BE UTILIZED AND DISCLOSED BY OUR DEPARTMENT AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS OF THE UPMOST IMPORTANCE TO US.

In the Department of Medical Services, we understand that the medical information of our patients is personal and confidential, for which we are committed to protecting and safeguarding the privacy and confidentiality of said information, in accordance with what is stated under the HIPAA Law. We will only use your information with the purpose of providing the treatment required at the moment of your visit.

Additionally, this law impedes us from disclosing information about you, your health, your treatment plan, and others, to any person without previous written authorization from you.

We utilize your information for the purpose of treatment, payment, and operations of the department, or in particular cases where the law demands, where no written authorization is required such as: organ and tissue donations, Air Force Members, workers compensation, public health risk, suspicion of abuse, investigation under the law, compliance with legal requirements, judges, medical examiners, and funeral directors.

Protected health information will be shared with family members and friends, if necessary, to assist with services provided, only if you approve. In case of emergency the use and disclosure of your information will be at our discretion.

SOME OF THE PATIENT'S RIGHTS

Inspection and copy: You have the right to review the health information we keep in your record. You may request a copy of this record. This request must be done in written form and will incur a low cost.

Registry of Disclosed Information: You have the right to request the details of the registry of disclosure that our department has realized concerning your health information. This request must be done in written form.

Restrictions Concerning the Requested or Disclosed Information: You can request additional restrictions and limitations for the use of your medical information. This request must be done in written form and include which specific persons you request have restricted access.

Request for confidentiality in communications: You have the right to request for the communication between you and the health professional treating you is done in an adequate place where privacy and confidentiality concerning your information is preserved. You may also express how and where you wish for the health professional communicates with you.

Amendments: You have the right to request amendments concerning your health information. This request must be Font in written form. This amendment can be denied, after being evaluated, for which you can request reconsideration.

Complaints Process: If you understand that your right to privacy and confidentiality concerning your health information has been violated, you may present a complaint in which you detail what happened to our department. You will not be penalized by presenting a complaint.

Ohter uses of medical information: Any other use or disclosure of the patient's medical information not covered in this notification, as well as covered or regulated by applicable federal or state laws, rules, or guidelines, shall be made only after written approval to that effect by the patient.

If you require or are interested in examining our Privacy Policy in more detail, you may request it from our Privacy Official or the director of the Department of Medical Services. Please note that, in accordance with the applicable legislation, our department reserves the right to review, modify, or amend the policy and practice about use and disclosure described in the notification at any moment.

For informational use of the patient, please do not turn this document in.

University of Puerto Rico: Mayagüez Campus
Dean of Students
Department of Medical Services

PRIVACY POLICY NOTIFICATION

AUTHORIZATION OF USE AND DISCLOSURE OF HEALTH INFORMATION

The University of Puerto Rico and its campuses in accordance with the federal law, Health Insurance Portability and Accountability Act (HIPAA) of the year 1996, and in conformity to Article 11 of law Number 194, Bill of Rights and Responsibilities of the Patient, of the year 2000, establishes the orientation and consent about the use and disclosure of patient's protected health information, prior to soliciting any health service in any of the Medical Services facilities.

As health service providers, the Departments and Offices of Medical Services (DSM/OSM) and all of its personnel have the obligation by law to protect and ensure confidentiality and privacy of patient's health information. The protected health information includes, but is not limited to: medical history, lab results, diagnostic tests and exams, medical or psychological evaluation and treatment, nurse intervention, symptoms and diagnostics, as well as any other information relating to medical care and health plans.

The protected health information will be used for: a) plan for your medical or psychological care and treatment, b) communication between health professionals that participate in caring for your health, c) information to determine a medical-surgical diagnostic, d) invoicing and service utilization audits on behalf of your insurance, e) quality and effectivity audits of services, and f) operating in accordance with laws, rules, and administrative orders issued by the Department of Health of Puerto Rico.

By signing this authorization, you authorize the DSM/OSM, through its personal and associates, to utilize and disclose the health information within the parameters permitted by law. This effectivity of this consent form is conditioned to soliciting and receiving medical services from the DSM/OSM of the university campuses of the University of Puerto Rico and will be valid while you are undertaking your university studies.

I certify that I have read the dispositions of this authorization, that I understand them, and that I agree with the terms and conditions expressed in this document.

Student Signature: _____

Student Name: _____

Student Number: _____

***Parent or Legal Tutor Signature:** _____

***Parent or Legal Tutor Name:** _____

Date: _____

Rev. Febrero 2023

University of Puerto Rico
Dean of Students
Department of Medical Services

DATE: 16th of January of 2025

UNIVERSITY OF PUERTO RICO: MAYAGUEZ CAMPUS STUDENTS / 2025-26

UNIVERSITY OF PUERTO RICO STUDENT HEALTH INSURANCE

The Department of Medical Services of the University of Puerto Rico: Mayaguez Campus, provides primary health services at a low cost directed towards all registered students in our campus with priority. Nonetheless, the University of Puerto Rico, with the purpose of looking out for the health of our students and complement the health services offered, establishes as Institutional Policy that all students registered in one curse of three or more credits must be insured by a valid health insurance in Puerto Rico.

If you are insured by a private or government health insurance valid for the semester you will be studying and do not wish to subscribe to the UPR's Health Insurance (Triple S), you must complete the required information by accessing: https://portal.upr.edu. Select the Mayaguez Campus ("Recinto de Mayagüez") and enter the Medical Documents icon, there you will find a tab called "Health Insurance". This information will be validated or rejected (if it does not meet the guidelines) by authorized personnel. If you are interested in any of the coverage plans of the health insurance offered by the UPR (Triple S), please review the list of costs for these coverage plans included in this document.

By not completing the process of updating your valid private/government health insurance information every semester in the online portal, https://portal.upr.edu, you will be automatically assigned the basic health insurance coverage plan contracted by the UPR (Triple S). **This will incur a financial charge which will be presented in your tuition bill.**

Any change you wish to make to your health insurance selection form must be done before confirming or paying your tuition bill. In general, changes are done during the adjustment period for courses selected, orientation week, or before the first day of classes in August 2025.

From the first day of class and onward, no student will be able to unsubscribe, change their selected coverage plan, or change from one health insurance to another. Be sure to make any changes before these dates.

If you require additional information, you can visit our offices or call (787) 832-4040 ext. 3408 / 3416.

Cordially:

Sra. Edna E. Acevedo Castro
Director
Department of Medical Services

Health Insurance Selection

(This form can be filled out digitally in portal.upr.edu accessing Medical Documents)

Name: **Student Number**:

Please select the alternative that applies to you:

Alternative I - Select, complete, and sign accordingly.

☐ **I am covered by a private or government health insurance,** and consequently **NOT** interested in subscribing to the UPR health insurance.

Select one: ☐ PRIVATE ☐ GOVERNMENT

Health Insurance Company Name: _____

Effective Coverage Dates: _____ to _____
mm/dd/yyyy mm/dd/yyyy

Every health insurance coverage has a beginning and expiration date of contract coverage, for which you must include the day, month, and years that correspond to these. If your coverage expires during the semester you will be studying, please select one of the following:

____Expected to be renewed ____Not Expected to be renewed

_____	_____	____ ___ 20__
Student Signature	**Parent or Legal Tutor Signature (for students under 21 yrs old)**	**mm/ dd/ yyyy**

Alternative II – Select, complete, and sign accordingly.

☐ **I am interested in subscribing to the University of Puerto Rico's Student Health Plan:**

Select one: ☐ INDIVIDUAL ☐ FAMILY

Note: See cost in next page.

SELECT THE DESIRED OPTION (select one):

☐ **Option A (Generic Medication)** ☐ **Option B (Brand and Generic Medication)**

SELECT THE DESIRED COVERAGE PLAN (select one):

- ☐ Basic with Pharmacy
- ☐ Basic, Pharmacy, and Dental
- ☐ Basic, Pharmacy, and Major Medical
- ☐ Basic, Pharmacy, Dental, and Major Medical

_____	_____	_____ _____20___
Student's Signature	**Parent or Legal Tutor Signature (for students younger than 21 yrs old)**	**MM / DD / YYYY**

Health Insurance Plan Cost contracted by the University of Puerto Rico, Triple S Salud.

Academic Year 2025-2026 ***Cost subject to change***

Covers generic medication with an $8.00 deductible.		*Covers generic medication with an $8.00 deductible.*	
Alternative **A *INDIVIDUAL***		Alternative **A *FAMILY***	
Basic with Pharmacy Coverage	*$463.00*	Basic with Pharmacy Coverage	*$1,032.00*
Basic, Pharmacy, and Major Medical Coverage	*$487.00*	Basic, Pharmacy, and Major Medical Coverage	*$1,088.00*
Basic, Pharmacy, and Dental Coverage	*$596.00*	Basic, Pharmacy, and Dental Coverage	*$1,264.00*
Basic, Pharmacy, Dental, and Major Medical Coverage	*$619.00*	Basic, Pharmacy, Dental, and Major Medical Coverage	*$1,320.00*

Covers brand and generic medication with a $5.00 deductible.		*Covers brand and generic medication with a $5.00 deductible.*	
Alternative **B *INDIVIDUAL***		Alternative **B *FAMILY***	
Basic with Pharmacy Coverage	*$1,083.00*	Basic with Pharmacy Coverage	*$2,271.00*
Basic, Pharmacy, and Major Medical Coverage	*$1,106.00*	Basic, Pharmacy, and Major Medical Coverage	*$2,327.00*
Basic, Pharmacy, and Dental Coverage	*$1,215.00*	Basic, Pharmacy, and Dental Coverage	*$2,503.00*
Basic, Pharmacy, Dental, and Major Medical Coverage	*$1,239.00*	Basic, Pharmacy, Dental, and Major Medical Coverage	*$2,559.00*

DEPARTMENT OF MEDICAL SERVICES UPRM/ CHECK LIST FOR PERSONAL USE

Utilize the following check list for the required documents as they are completed.

Remember that the three (3) documents marked with * must be submitted to the online portal and their original copies turned in to the Department of Medical Services.

1	**Medical History - Part A:** Completed by the student. (Must be signed by the student and a parent or legal tutor is student is below 21 years old)
2.	**Medical Form – Physical Exam- Part B** (Completed by a medical doctor**)**
3	**Tuberculin test or Chest X-Ray Reading** (No more than a year old, athletes must turn in both). In case of a postitive Tuberculin test, present evidence of medical treatment.
4	**VDRL/RPR** (No more than six months old)
5	**Blood Test** - Hepatitis B Surface Antibodies Quantitative (No more than six months old)
6	***C**ertificate of Immunization -PVAC-3- Green Sheet (original)* Evidence of all your vaccines and up-to-date according to age. If older than 21 years old, you must have an up-to-date TD Vaccine. ***If you were administered Covid-19 vaccines, present evidence of these* or Vaccine Exemption Document of the Department of Health (This document is valid for a year), if applicable.***
7	***Authorization to Receive Medical Attention Form** (Sworn Affidavit) If you are younger than 21 years old, the document must be notarized and include the seal for Legal Assistance. **If you are older than 21 years old, submit the Evaluation Consent Form.**
8	**Receipt of Privacy Policy Notification-HIPAA Law** (signed by student and parent or legal tutor)
9	**Health Insurance Selection – Must be completed digitally accessing: portal.upr.edu, /"Medical Documents"/ "Health Insurance".** If you select the UPR Health Insurance Plan, for more information and cost visit: https://www.uprm.edu/serviciosmedicos **.** Cost table will be attached for use as reference.
10	**Photograph 2x2** (picture of your face, official and from the front.)

IMPORTANT:

- ***Keep a copy of all documents.***
- ***Due date to submit documents is: June 10th, 2025.***

UNIVERSITY OF PUERTO RICO
MAYAGUEZ CAMPUS
DEAN OF STUDENTS

DEPARTMENT OF MEDICAL SERVICES

Consent Form for Receiving Treatment
STUDENTS OF 21 YEARS OF AGE OR OLDER

I,_____, of legal age (_____), _____,
STUDENT FULL NAME AGE CIVIL STATUS

and legal residence in _____, _____, in my personal capacity as a
CITY STATE

student of legal age with full physical and mental capability to decide, hereby:

Authorize the staff authorized by the Honorable Secretary of the Department of Health of the Commonwealth of Puerto Rico in any branch of medicine and give their services in the Department of Medical Services or its Offices and the Campuses of the University of Puerto Rico, to receive medical attention if necessary for the purpose of preserving the health and reduce the harm or impediment that could occur as a consequence of an accident or an illness while I study or practice a sport in the facilities of the Campus or University or any other facility not belonging to the latter, and to be diagnosed, treated, performed, or practiced any corrective therapeutic measures understood to be pertinent and administer the medication and/or treatments prescribed in accordance to the laws of the Commonwealth of Puerto Rico. I give authorization to be referred to other medical doctors and/or hospital institutions dully accredited by the Department of Health of the corresponding area, following the established privacy norms.

For the record; signed and authorized the_____ of_____of 202____

in _____, _____.
CITY STATE

_____ _____
STUDENT'S SIGNATURE Witness (Any known person)

XXX-XX- _____ _____
Last four (4) numbers of Student's Social Security Student Number