Universidad de Puerto Rico
***RECINTO UNIVERSITARIO DE MAYAGÜEZ***
Decanato de Estudiantes
CALL BOX 9000
MAYAGÜEZ PUERTO RICO 00681-9000
Tel. (787) 832-4040 - Ext. 3405

***DEPARTAMENTO DE SERVICIOS MÉDICOS***

UPR
Universidad de Puerto Rico

University of Puerto Rico
***MAYAGÜEZ CAMPUS***
Office of the Dean of Students
CALL BOX 9000
MAYAGÜEZ PUERTO RICO 00681-9000
Tel. (787) 832-4040 - Ext. 3405

***HEALTH SERVICES DEPARTMENT***

November 6, 2026.

**NEW ADMISSION/ GRADUATE SCHOOL/ READMISSION/ TRANSFER WITHIN UPR SYSTEM/ EXTERNAL TRASFER/ INTERNATIONAL AND EXCHANGE/ SPECIAL PERMIT/ PROFFESIONAL DEVELOPMENT STUDENTS FOR JANUARY 2027**

Welcome to the "*antes, ahora y siempre* ***COLEGIO.***"

In accordance with **Certification 23-24-145** issued by the UPR Administrative Board, you must submit a series of documents to the Department of Medical Services prior to your enrollment process. Not meeting these requirements will affect your enrollment process impeding your access and payment of tuition on time.

The required documents are attached with this notice. These must be completed in all their parts, including your full name and institutional student number assigned upon admission. Afterwards the documents must be uploaded in the corresponding order in pdf format to the UPR Portal (**https://portal.upr.edu)** accessing the Medical Documents icon.

***The deadline to submit the corresponding documents onto the online portal is Monday, November 16, 2026.*** Upon accessing Medical Documents, you must first: complete the information on the health insurance selection form. If you have private or government health insurance (valid for at least January 2027) and have no interest in subscribing to any of the coverage options offered by the UPRM, you must submit your health insurance's information in the initial tab. After completing and saving this information, proceed to the second tab to upload the required documents for your enrollment. Your health insurance information must be updated every semester prior to paying your tuition for the following semester.

In compliance with the law, no documents will be accepted through email, nonetheless, if you are unable to access the online portal, you may bring the documents in-person to the Department of Medical Services, deposit them in the mailbox located at the University Guard offices (open 24/7), or send them via postal service. We highly recommend keeping a copy of

the submitted documents.

Out of all the documents, the following three (3) are required to be delivered in-person in addition to uploading them to the online platform:

1. Original vaccination certification that includes COVID vaccinations if any.
2. Vaccination exemption form from the Department of Health of P.R. as applicable.
3. Notarized Sworn Affidavit (for under 21-year old's) or Consent for Medical Evaluation and Treatment (for older than 21-year old's).

**These documents must be turned in personally or by postal service to the Department of Medical Services.**

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

Due to the current scarcity of tuberculin test in Puerto Rico and in accordance to the **Administrative Order 2026-654**, issued by the Secretary of Health of Puerto Rico, Dr. Victor M. Ramos Otero, this past 7th of October of 2026, we will be exonerating the requirement of this test temporarily for all students admitted for January 2027. We will be notifying students at a later date, wherein you will receive specific instructions in order to meet the requirement of the tuberculin test.

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

We wish you success in your future university career, and are at your service.

Cordially,

Mrs. Edna E. Acevedo Castro
Interim Director

*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)<br>1. _____Relation_____Tel. ( )_____-_____<br>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**

**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

## 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**