****UNIVERSIDAD NACIONAL AUTÓNOMA DE HONDURAS

FOTO TAMAÑO CARNÉ

FACULTAD DE CIENCIAS MÉDICAS

COORDINACIÓN GENERAL POSGRADOS

FICHA DE REGISTRO PARA EXAMEN

|  |  |  |  |  |
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| Especialidad que aplica: | 1ª Opción | Elija un elemento. | 2ª Opción | Elija un elemento. |

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| DATOS GENERALES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Primer nombre | | | | |  | | | Segundo nombre | | | | | | | | | | | | | |  | | | Primer apellido | | | | | | | | | | | | | | |  | Segundo Apellido | | | | | | | | | | | | | | | |  | | Identidad/pasaporte(E) | | | | |
| Sexo: Elija un elemento. | | | | | | | | | | | | | | | |  | E. civil: Elija un elemento. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Edad (años): | | | | | | |
| Fecha de nacimiento: | | | | | | | | | | | | | | | | | | | | | | |  | | | Nacionalidad: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Nº Hijos: | |
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| Tel: Celular Nº | | | | | | |  | | Tel: fijo | | | | | | | | | | | | | | | | | |  | Correo electr. personal | | | | | | | | | | | | | | | | | | | | | | |  | | | Correo electr. alternativo | | | | | | | | | |
| ESTUDIOS – PROCEDENCIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| UNIVERSIDAD: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | País: | | | | | | | | | | | |  | | |
| Teléfono: |  |  | | | | | | | | | | | | | | | | |  | | | | | Correo institucional: | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | |
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| Fecha de ingreso | | | | | | | | | | |  | | Fecha de egreso | | | | | | | | | | | | | | | | | | | | | |  | | | Fecha de graduación | | | | | | | | | | | | | | | | |  | | | Índice de graduación (%) | | | | | |
| LUGAR DE RESIDENCIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | Elija un elemento. | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |
| País | | | | | | | | | |  | | Departamento | | | | | | | | | | | | | | | | | | | |  | | | | Municipio | | | | | | | | | | | | | | | | | | | |  | | | | Colonia / Barrio | | | |
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| Calle | | | | | | | | | |  | | Avenida | | | | | | | | | | | | | | | | | | | |  | | | | Numero de Casa | | | | | | | | | | | | | | | | | | | |  | | | | Teléfono fijo | | | |
| SITUACIÓN LABORAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombres Instituciones donde labora: | | | | | | | | | | | | | | | | | | A | |  | | | | | | | | | | | | | | | | | | | | | | | | B | | |  | | | | | | | | | | | | | | | | |
| Institución tipo: | | | | A | | Elija un elemento. | | | | | | | | | | | |  | | |  | | | | | | | | | B | | | Elija un elemento. | | | | | | | | | | | |  | Correo(A) | | | | | | | | | | | | | | | | | |
| Correo(B) | | | | | | | | | | | | | | | Telf.(A) | | | | | | | | | | | | | | | | | | | Telf. (B) | | | | | | | | | | | | | | | | Años en (A) | | | | | | | | | | | | | Años en (B) |
| Dpto. (A) Elija un elemento. | | | | | | | | | | | | | | Mpio. (A): | | | | | | | | | | | | | | | | | Dpto. (B) Elija un elemento. | | | | | | | | | | | | | | | | | | | | | | Mpio. (B): | | | | | | | | | | |
| CONDICIÓN DE SU SALUD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enfermedad: Elija un elemento. | | | | | | | | | | | Tratamiento: Elija un elemento. | | | | | | | | | | | | | | | | | | Embarazo: Elija un elemento. | | | | | | | | | | | | | | | | | | | Limitación/discapacidad: Elija un elemento. | | | | | | | | | | | | | | | |
| Diagnostico: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Medicación: | | | | | | | | | |  | | | | | | | | | | | | | | |
| Doy Fe que he leído y entendido los requisitos, forma, reglas, instrucciones del instructivo publicado en la web para proceso de admisión 2018 - 2019 a los posgrados clínicos de la FCM / UNAH al que me someto con pleno conocimiento. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Fecha (día / mes / año) |  |  |  |

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Firma Aspirante Impresión (Sello de colegiación o dactilar)

IMPRIMIR Y ENVIAR AL CORREO: [ingresoposgradofcm2018@gmail.com](mailto:ingresoposgradofcm2018@gmail.com)