**IDENTIFICACION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| APELLIDO PATERNO | | | APELLIDO MATERNO | | | | NOMBRES | | |
|  |  | | |  | |  | |  | | |
| RUT | | | EDAD | | | | NACIONALIDAD | | |
|  | |  | | |  |  | | |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DOMICILIO | **:** |  | | | |
|  |  |  | | | |
| TELÉFONOS | **:** |  | CELULAR |  |  |
|  |  |  |  |  |  |
| E - MAIL | **:** |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TÍTULO PROFESIONAL | : |  | | | |
|  |  |  | | | |
| UNIVERSIDAD | : |  | | | |
|  |  |  | | | |
| SEDE | : |  | FECHA | : |  |

**CERTIFICACIÓN DE ESPECIALIDAD**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ESPECIALIDAD |  |  | | | |
|  | | | | | |
| INSTITUCIÓN QUE LA OTORGÓ |  |  | FECHA |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ESPECIALIDAD |  |  | |
|  |  |  | |
| AÑOS DESEMPEÑO ESPECIALIDAD |  |  | |
|  |  |  | |
| HOSPITAL |  |  | |
|  |  |  | |
| AUTORIDAD QUE EMITE CERTIFICADO DE DESEMPEÑO ESPECIALIDAD: | | |  |

1. **Sector Público (adjuntar relación de servicios)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| INSTITUCION | : |  | | |
|  | | | | |
| ESPECIALIDAD | : |  | HORAS |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| INSTITUCION | : |  | | |
|  | | | | |
| ESPECIALIDAD | : |  | HORAS |  | |

Inscrito en el registro de Prestadores Individuales de la Superintendencia de Salud

|  |  |  |  |
| --- | --- | --- | --- |
| **SI** |  | **NO** |  |

**MANTIENE CONVENIO SUSCRITO ACTUALMENTE (2024) BAJO ESTA MODALIDAD EN EL SSMS \_\_\_\_\_\_\_\_\_ SI/NO**

**ESTABLECIMIENTO(S) A LOS QUE POSTULA:** (Marcar con una x)

|  |  |
| --- | --- |
| HOSPITAL BARROS LUCO TRUDEAU |  |
| HOSPITAL EXEQUIEL GONZALEZ CORTES |  |
| HOSPITAL SAN LUIS DE BUIN |  |

**PRESTACION A LA QUE POSTULA:** (**señalar tal como indica el LLAMADO**)

Especialidad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prestación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  |  |
|  | FIRMA |

*Fecha,……………………………………………………………………*