**ANEXO N°9**

**FORMULARIO DE RENUNCIA CUPO DE ESPECIALIZACION**

**PROCESO DE SELECCIÓN LOCAL SERVICIO DE SALUD O´HIGGINS AÑO 2024**

**CUPO N.º \_\_\_\_\_\_\_\_\_\_\_**

**APELLIDO PATERNO**

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**APELLIDO MATERNO**

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**NOMBRES**

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**RUN TELEFONO (Móvil o Fijo)**

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**SERVICIO DE SALUD DE DESEMPEÑO/MUNICIPALIDAD DE DESEMPEÑO**

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**ESTABLECIMIENTO DE DESEMPEÑO**

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**REGIÓN Y COMUNA DEL ESTABLECIMIENTO DE DESEMPEÑO**

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**ESPECIALIDAD TOMADA : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**UNIVERSIDAD : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CAMPO CLINICO : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DURACION : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Declaro que renuncio al cupo de especialización obtenido en este proceso de selección.**

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Firma Postulante

FECHA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_