**ANEXO N°10**

 **FORMULARIO DE RENUNCIA CUPO DE ESPECIALIZACIÓN**

**PROCESO DE SELECCIÓN LOCAL SERVICIO DE SALUD MAGALLANES AÑO 2024**

**CUPO Nº \_\_\_\_\_\_\_\_\_\_\_**

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_