OFFICE OF GRADUATE MEDICAL EDUCATION RESIDENT CHECK OUT FORM 2018

This form must be completed by all residents terminating with The George Washington SMHS. Please give us your name, present department/division, and your new location, position and forwarding address below. Have the blanks below signed to indicate that you met clearance requirements for each item. Only signatures of those named below are acceptable for each item.

Department	Time	Authorized Signatures
Medical Records – HOSP G2036	Monday through Friday 8:00am to 3:00pm	Michelle Canter Chiriaco ; Rachelle Norris, Ernestine Palmer, Janice Turner, Cindy Arnez, Millicent Shand, Florence Phillips
Touchworks – MFA system		Your residency program director or coordinator must verify that all of your tasks have been completed in Touchworks.
Himmelfarb Library	Monday through Friday 8:00am to 4:30pm	Kathy Lyons, Julie Silverman, Alexandra Gomes, Catherine Sluder, Elaine Sullo, J. Marie Miller, Anne Linton, Steve Bryant
Your Program (return your pager, call room keys and any departmental/university property to your program coordinator)		Your residency program director or coordinator. This applies to residents and fellows in all departments.
Graduate Medical Education Office: see list	Monday through Friday 8:00am to 4:30pm	Mary Tucker, Mary Mosby, Stephanie Morgan, Atoya Saturria-Feliz **Note:** No checkout during Orientation June 13-15 and July 2 & 3

Your residency certificate will be released when this completed form is presented to the GME Office, Ross Hall, #718.

Name: _____ **Program :** _____

New Position:_____

Forwarding Address:_____

_____

Personal Email Address:_____ **Cell Phone:** _____

NOTE: Prior to leaving George Washington University, please log into the GWEB info systems and verify your home address so we can be sure your W-2 form is routed appropriately.

OBTAIN SIGNATURES BELOW:

Medical Records:_____ **Date:**_____

Touchworks: _____ **Date:**_____

Library:_____ **Date:**_____

Program Signature:_____ **Date:**_____

GRADUATE MEDICAL EDUCATION OFFICE:

- **EXIT SURVEY COMPLETED: YES** _____ **NO** _____
- **Photo IDs:** GME staff must sign to indicate receipt

  Hospital ID_____ **GWorld ID** _____ **Date:** _____
- **6th Floor Keys** *(Fellows only)* _____ **Date**: _____
- **Residency Certificate:** Resident must sign to indicate receipt or request for mailing

  Received from Dept._____

  Received from GME:_____ **Date:** _____

  ***Please mail to above address:** _____ **Date mailed:** _____
  ***Self-addressed mailing label is completed by resident and attached to this form:** _____

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

SCHOOL OF MEDICINE AND HEALTH SCIENCES

OFFICE OF GRADUATE MEDICAL EDUCATION

Authorization and Release of Information
GWU Residents/Fellows

I hereby authorize The George Washington University School of Medicine and Health Sciences (GWU), its Office of Graduate Medical Education (GME), its faculty, deans, program directors and administrative or other staff to provide verbal or written information regarding verification of my training at GWU, my professional competence, character and ethical qualifications to program directors, administrators and members of the staffs of other residency/fellowship programs, institutions, credentialing organizations, licensing agencies or any others whom I have authorized to receive such information. I further consent to the release of all documents, including GME files, program files, evaluations, or any other material requested by the above entities.

I hereby release from liability all representatives of GWU, including its GME Office, faculty, deans, program directors and administrative staff for all acts performed in good faith and without malice in connection with the release of any information provided pursuant to this authorization.

A photocopy of this form shall have the same effect as the original.

_____
Name (please print)

_____
Signature

_____
Date

ROSS HALL, SUITE 707 • 2300 EYE STREET, NW • WASHINGTON, DC 20037 • 202-994-3893 • FAX 202-994-1604