RESIDENT CLEARANCE FORM

All Residents are required to complete the clearance form on the final day of clinical rotations at CHRISTUS Santa Rosa Health Care, or prior to graduation (whichever comes first).

NAME:____GRADUATION DATE:____________________

SPECIALTY:_______________________________PROGRAM DIRECTOR:_____________________________

PLEASE CLEAR IN THE ORDER PRESENTED. DEPARTMENTS LISTED MUST INITIAL AND DATE AS INDICATED.

MEDICAL RECORDS **INITIALS: __________ DATE: __________**
(Record Completions, Dictations, etc.)

GRADUATE MEDICAL EDUCATION **INITIALS: __________ DATE:__________**
(ID Badge, Parking hangtag, clear from system)
Center for Children's and Families (CCF) 5th Floor

_______ID Badge _______Daily Meal Card

_______Parking tag _______On Call Meal Card

_______Keys

Signature of Resident:___________________________________ Date: _________________