

**UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER/GAINESVILLE
TERMINATION CHECKLIST**

COMPLETE FOR ALL TERMINATING RESIDENTS

NAME _____ SSN _____

PROGRAM/DEPARTMENT _____ DATE _____

RESIDENT DESTINATION: ___ entering private practice; ___ entering military; ___ continuing graduate medical education; ___ other (specify)

FORWARDING ADDRESS: _____

PERMANENT ADDRESS: _____

___ 4. W-4

___ 5. Health Insurance Status Change Form

___ 6. Resident Clearance Form (submit in June when program has been completed)

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE ALUMNI AFFAIRS

___ 1. Medical school attended and year of graduation _____

___ 2. Beginning appointment date _____

___ 3. Termination date _____

___ 4. Title at time of termination _____

**THIS ADDITIONAL INFORMATION IS ONLY REQUIRED if termination was not completed by May 1
(the deadline for terminations that will be included in the UF Dataset)**

___ 1. Resident Termination Coding Sheet

- Complete #1, 2, and 18
- Complete #20 (Employee Status Code for Termination is "31")

___ 2. Form 255

RESIDENT/FELLOW CLEARANCE FORM
UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER/GAINESVILLE

Name: _____ Department: _____

Social Security Number: _____

I will be: ___ entering private practice; ___ entering military; ___ continuing graduate medical education; ___ other (specify)

Forwarding address (if unknown, please provide a permanent address below where information may be sent): _____

_____ Phone: _____

Permanent address: _____

_____ Phone: _____

Name and Address of hospital or group practice:

_____ Phone: _____

The five departmental sections below have been completed:

Signature _____ Date _____
Program Assistant

- Beeper
- All keys (lounge, locker, etc) & keycards
- Departmental Requirements
- ID badge
- Health insurance status change form

I verify that all personalized Shands Gainesville prescription pads have been destroyed by me or turned into Pharmacy. I am aware that upon departure from the University of Florida and Shands Gainesville, I am no longer able to use these prescription pads.

Signature of Resident/Fellow: _____ Date _____

All of the above sections have been completed. Medical records, Borland Library, parking fines and hospital accounts are listed as completed. In addition, there are no outstanding loans with the Attending Staff Foundation or the Office of Educational Affairs Emergency Loan Fund for Residents. I have given the resident/fellow a copy of this clearance form.

Signature: _____ Date _____
Office of Educational Affairs

COBRA forms for continuing your health insurance, should you wish to do so, will be mailed to the **permanent address** listed above. If you have any questions concerning your COBRA coverage, please call Cynthia Stroup (352-392-8188)

RESIDENT TERMINATION CODING SHEET
UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER/ GAINESVILLE

This form must be completed for the following actions: NEW, TERMINATIONS, CHANGE IN DEPARTMENT, OCCUPATION CODE & VISA CHANGES. Resident appointments cannot be completed by the Personnel Office without this important information. Please complete the following before submitting Resident appointments for processing: (#'s 8, 9, 10, 11, 14, 19, 20, 21, and 22 require defined codes.) See coding instructions. Appointments will be returned to the department if coding sheet is not attached.

1.	Social Security Number	_____
2.	Name (Last, First, Initial)	_____
3.	Sex	_____
4.	Birth date (Month, Day, Year)	_____
5.	Race (Code Required)	_____
6.	Current employment beginning date (Month, Day, Year)	_____
7.	Employment date with the College of Medicine	_____
8.	Occupation Code (Resident 7185H or Chief Resident 71C5H)	_____
9.	Department and Division to which assigned (Code required)	_____
10.	USA Citizenship (use appropriate code please) OR	_____
	Foreign Citizenship (Code for Visa Type; also write in	
	Issue and Expiration Date)	_____
11.	PMD year	_____
12.	PMD Effective Date	_____
13.	School of Graduation (Code Required)	_____
14.	Date of Graduation (Month, Day, Year)	_____
15.	Insurance Effective Date	_____
16.	Insurance Coverage (F=family or S=single)	_____
17.	BOM Registration date (employment date) or Florida License # issue and expiration dates	_____
18.	Training program and (anticipated or absolute) completion date (Code Required)	_____
19.	Sub-specialty (if applicable). Please list correctly if an approved sub-specialty for fellows. (Code Required)	_____
20.	Employee Status Code (Code Required)	31 _____
21.	Type of degree earned (Code Required)	_____
22.	Title of new Resident	_____
23.	Address (Local address if new appointment. Permanent address if terminating appointment)	_____ _____ _____

Note: If not a new appointment, fill in SS#, Name, and the appropriate changes only! DO NOT COMPLETE THE ENTIRE FORM