Clearance and Termination Information for Residents/Fellows
University of Florida College of Medicine - Jacksonville

Name:_____ UFID:_____

Department:_____ Start Date:_____

Termination Date:_____

Medical School:_____ Grad Date:_____

ALUMNI INFORMATION to be completed by the Resident (all information must be provided):

I will be: entering private practice; entering military; continuing medical education; other_____

Local Home Address (This address is to be entered in the UF Directory—W-2 will be sent to this address):

Address:_____ E-Mail:_____

City, State, Zip:_____ Phone:_____

Permanent Home Address (i.e. next of kin not living with you or foreign address): Check Box if same as local

Address:_____ E-Mail:_____

City, State, Zip:_____ Phone:_____

Work Data (i.e. Name and Address of new employer, hospital, or group practice): Used for statistical purposes only

Hospital or Group Practice:_____ Specialty:_____

Address:_____ E-Mail:_____

City, State, Zip:_____ Phone:_____

Please initial the items below after completion:

_____I verify I have updated my NPI Contact Information via the web.

_____I verify I have updated my address in the UF directory with the address I want my W-2 to be sent to and have removed consent for receipt of electronic W-2.

_____I verify that I have received the FICA Alternative Distribution Form regarding closure or roll-over alternatives of my account and understand it is my responsibility to mail or fax the form to the plan administrator.

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

_____I have read and signed the email attestation form and understand my @jax.ufl.edu email account will not be accessible after my termination date.

COBRA forms, for continuing your health insurance, have been mailed to the current home address as shown in the UF Directory. If you have any questions concerning your COBRA coverage, please call the UFCOM-J Benefits Coordinator at (904) 244-8531.

Resident Signature:_____ **Date:**_____

Items to be returned to Program Coordinator

____1. Beeper
____2. ID badge
____3. Keys (call quarters, locker, etc.)
____4. Meal Card
____5. Call Quarters Lock
____6. Parking Card
____7. Email Attestation

Departments cleared

____8. EPIC
____9. Attending Staff Foundation Loans
____10. Departmental Requirements
____11. Library – fines or usage charges paid
____12. Medical Records (SHJ and BMC) – all charts signed

____ All of the above sections have been completed. The resident's *Forwarding/Alumni* and *Hospital/Group Practice* addresses have been updated in New Innovations. A copy of the clearance form is to be given to the resident with their certificate.

Coordinator Signature:_____ **Date:**_____

Certificate given to:_____

OEA Signature:_____ **Date:**_____