# WCGME Checklist for Graduating Residents

Name: ________________________ Residency Program:__________________________ Completion/Term Date _______________

Completed Residency ☐ Did Not Complete Residency ☐ Completed Preliminary Year Only ☐

**Future Plans:**

☐ Group/Private Practice ☐ Further Residency Training ☐ Faculty/Staff - Via Christi ☐ Faculty/Staff - Wesley

☐ Fellowship: Specialty: ________________________________ Where: ___________________________________

☐ Other ______________________________________________________________________________________

**Forwarding Addresses:**

| | Professional | Home |
|---|---|---|
| Practice Name | | |
| Street | | |
| City/State/Zip | | |
| County (KS only) | | |
| Email | | |
| Phone Number | | |

**Medical Records Completed:**

| | Signature - HIM Director or Designee | Date |
|---|---|---|
| Wesley | | |
| Via Christi | | |
| VA | | |

**Clinic Records Completed:**

| | Signature - Clinic Director or Designee | Date |
|---|---|---|
| Wesley | | |
| Via Christi | | |
| KU | | |

**Program Office:**

| Case Counts & Evals Completed | Pager Returned FMW, FMVC, OB Peds, Rad | MKSAP CD & Books | Time Records Completed | Certificate of Completion | Signature | Date |
|---|---|---|---|---|---|---|
| Yes/No | Yes/No | Yes/No | Yes/No | Yes/No | | |

**Wesley Medical Education Office:**

| Hospital Badge Returned & Deactivated | Signature | Date |
|---|---|---|
| Yes/No | | |

**Via Christi Medical Education Office:**

| Hospital Badge Returned & Deactivated | Portfolio | Pager | Laptop (charger, cord, battery, bag) | Signature | Date |
|---|---|---|---|---|---|
| Yes/No | Yes/No | Yes/No | Yes/No | | |

**WCGME Office:**

| Pager Returned – Anesth, IM, Med/Peds, Ortho, Psych, Surg | KU Access Card | Library Cleared | Time Records Completed | Signature | Date |
|---|---|---|---|---|---|
| Yes/No | Yes/No | Yes/No | Yes/No | | |

***I attest that I have received my Certificate of Completion & all requirements in the checkout process are complete.***

_________________________________________________ ________________________________

Resident Signature Date