

MUSC OFFICE OF GRADUATE MEDICAL EDUCATION  
RESIDENT CLEARANCE SHEET

I, \_\_\_\_\_, signify by the signatures below that I have no unfulfilled commitments or outstanding obligations as a specialty/subspecialty resident at MUSC.

1. **RALPH H. JOHNSON VA MEDICAL CENTER ID BADGES:**  
The badge must be returned directly to the GME Office.  
Received by: \_\_\_\_\_
2. **CONTROLLED SUBSTANCE OFFICE:**  
Prescription validation (i.e., plastic) card must be returned to your Department.  
Received by: \_\_\_\_\_
3. **IDENTIFICATION BADGE:**  
Your ID badge must be returned to your Department:  
Received by: \_\_\_\_\_
4. **MEDICAL RECORDS:**  
Any outstanding medical records (including primary care records) must be presented to  
Your Program Director or his/her designee.  
Received by: \_\_\_\_\_
5. **PARKING LOT ACCESS CARDS AND LOT KEY:**  
Your parking lot card and/or lot key must be returned to the Parking Management  
Office located on the second floor of Parking Lot E.  
Received by: \_\_\_\_\_
6. **SIMON PAGER:**  
Your pager must be returned to the Communications Office located in  
room 243 of the North Tower of MUH. Received by: \_\_\_\_\_
7. **LIBRARY FINES AND/OR FEES:**  
I certify that s/he has no outstanding fines and/or fees.  
Received by: \_\_\_\_\_

**PLEASE NOTE:**

**YOUR FINAL PAYCHECK WILL BE GIVEN TO YOU BY YOUR PROGRAM DIRECTOR. COLLECTION OF ANY FINES OR REPLACEMENT COSTS WILL BE THE RESPONSIBILITY OF THE DEPARTMENT.**

**NEW POSITION**

Residency or Fellowship \_\_\_\_\_ Institution: \_\_\_\_\_

Academic Faculty: \_\_\_\_\_ Institution: \_\_\_\_\_

Private Practice Address: \_\_\_\_\_

Other \_\_\_\_\_

W2 FORWARDING ADDRESS: \_\_\_\_\_

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Please return this form to the Office of Graduate Medical Education, 202 Main Hospital or your program coordinator. For questions, call 792-2575 or 792-9304.

**YOU WILL RECEIVE YOUR PROGRAM CERTIFICATE UPON COMPLETION OF THIS CLEARANCE SHEET.**