COMMUNITY MEDICAL CENTER
From day one.

Medical Resident Checklist/Requirement Verification

Resident's Name ______ Resident's Phone # ______

Resident's Email ______ Resident/Program ______

Date(s) of Residency ______ Resident's Date of Birth ______

Resident's Emergency Contact ______ Emergency Phone # ______

This form is to be completed by an authorized resident program representative.

Resident's Name ______ Please Print First and Last Name	Date Reviewed	Resident Program Representative Initials
1. **Immunizations:** I am verifying that the information on the resident's immunization verification form has been obtained from the resident's records on file with the resident program.		
2. Background Check: I verify that a criminal background check, exclusion list check from Office of Inspector General (OIG) http://exclusions.oig.hhs.gov/ and national sexual offender registry search http://www.nsopw.gov/en-us has been completed on this student. I am verifying that the results show no records without discrepancies		
3. Drug Screen: I am verifying that the information on the student's 10 panel drug screen is no more than 30 days from the start of the school year; I am verifying that the results show no discrepancies		
4. **Random Audits:** I understand the ORGANIZATION will conduct random audits of the above information. Failure to comply with all requirements or not have complete records on file for a resident may result in termination of the clinical experience for one or all residents from this resident program.		
5. I verify the above statements to be true. I have reviewed and understand all the information that has been given to the students in the Resident Checklist and Orientation Manual.		

Authorized Resident Program Rep Signature ______ Date ______

Print Name ______ Phone # ______

Email address ______

Updated 2019