



AMERICAN
BOARD OF
RADIOLOGY

RESIDENT WITHDRAWAL/TERMINATION NOTIFICATION

Please note, this form should only be used for residents who have withdrawn from the specialty or **are not transferring** to another residency at this time.

RESIDENT INFORMATION

DATE: _____

RESIDENT
NAME:

(First, Middle, Last)

ABR ID: _____ *(optional)*

DOB: _____
MM/DD/YYYY

RESIDENCY TRAINING INFORMATION

PROGRAM:

- Diagnostic Radiology (DR) Interventional Radiology (IR) Radiation Oncology (RO)

*Please select **one** of the options below.*

- The above named applicant successfully completed training with our program from _____ to _____ and received credit for **all** training completed.

OR

- The above named applicant completed training with our program from _____ to _____ and only received _____ months credit for training completed.

If the resident transferred to another specialty, please include the specialty: _____

PROGRAM DIRECTOR NAME:

(Printed Name)

PROGRAM DIRECTOR SIGNATURE: _____