RESIDENT TRANSFER NOTIFICATION

RESIDENT INFORMATION

DATE: _____

RESIDENT NAME: _____
(First, Middle, Last)

ABR ID: _____ *(optional)* DOB: _____
MM/DD/YYYY

Complete the section(s) below that are applicable to your program. If a resident is transferring from Diagnostic Radiology to Interventional Radiology, please complete both sections.

TRANSFER RELEASE

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.

Please provide the name of the resident's new program: _____

TRANSFER ACCEPTANCE

PROGRAM: _____

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

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

☐ The above named applicant transferred into our program on _____ and received credit for all previous training completed. Their anticipated graduation date is _____.

OR

☐ The above named applicant transferred into our program on _____ and will be repeating training. Their anticipated completion date is _____.

PROGRAM DIRECTOR NAME: _____
(Printed Name)

PROGRAM DIRECTOR SIGNATURE: _____