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Please note, this form should only be used for residents who have withdrawn from the specialty or are not transferring to another residency at this time.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

__________________________________________