# 2016-17 Fellowship Document Submission Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Deadline Details</th>
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<tr>
<td>Fellowship Submission (Initial Appointments)</td>
<td>Actual Deadline: March 1, 2016</td>
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<td>*Final Deadline: March 15, 2016</td>
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<td>Reappointments (submit Stipend B only)</td>
<td>Actual Deadline: January 29, 2016</td>
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<td>*Final Deadline: March 15, 2016</td>
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<tr>
<td>Revised Funding (submit Stipend B)</td>
<td>Deadline: *March 30, 2016</td>
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<tr>
<td>Completion of Training Certificate Request Form</td>
<td>Deadline: April 1, 2016</td>
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<td>Sign-out Sheet</td>
<td>Deadline: one week prior to actual end date</td>
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* Submission after the final deadline date will require an email explanation for additional time. Thank you.
McGaw Medical Center of Northwestern University
Graduate Medical Education

Initial [ ] Reappointment [ ] Revised Funding Source [ ] Revised Appointment Dates [ ]

Dept. - Division: ______________________ Subspecialty: ______________________

NAMF/ADV. Training & Research Program Y: [ ] N: [ ]

Clinical Fellow Name: ______________________ (Last) ______________________ (First)

Male [ ] Female [ ] Social Security Number ______ - ______ - ______ (IMG) SS# Applied for: Y: [ ] N: [ ]

PGY Level Fellowship [ ] Appointment Dates From: _____________ To: _____________
(Note: Appointments should be for one year only- New Stipend B required for each year of training)

International Medical Graduate [ ] Yes [ ] No [ ]

Vista Type: J-1 [ ] H1B [ ] Permanent Resident [ ]

ECFMG #: __________________

Date Issued: ______________
(Attach a copy of ECFMG certificate)

Illinois Medical License Current [ ] Yes [ ] No [ ] Expiration Date: ______________
(Attach a copy of current License)

Funding Source Required - please select below upon submitting Stipend B

[ ] LCH (Lurie Children's Hospital) [ ] RIC (Rehabilitation Institute of Chicago)

[ ] VA (Veteran Administration) [ ] Dept. - Division

Print Program Director Name: ________________________________

Signature of Program Director: ______________________________ Date: ______________

Signature of Funding Source Mgr.: __________________________ Date: ______________
McGaw Medical Center of Northwestern University
Graduate Medical Education

Initial ☐ Reappointment ☐ Revised Funding Source ☐ Revised Appointment Dates ☐

Dept. - Division: ___________________________ Subspecialty: ___________________________
NAMF/ADV. Training & Research Program Y: ☐ N: ☐

Clinical Fellow Name: ___________________________ (Last) ___________________________ (First)

Male ☐ Female ☐ Social Security Number _______ - ____ - _______ (IMG) SS# Applied for: Y: ☐ N: ☐

PGY Level Fellowship _______ Appointment Dates From: ___________________________ To: ___________________________
(Note: Appointments should be for one year only. New Stipend B required for each year of training)

International Medical Graduate Yes ☐ No ☐

Vista Type: J-1 ☐ H1B ☐ Permanent Resident ☐ ECFMG #: ___________________________
Date Issued: ___________________________
(Attach a copy of ECFMG certificate)

Illinois Medical License Current Yes ☐ No ☐ Expiration Date: ___________________________
(Attach a copy of current License)

Funding Source Required - please select below upon submitting Stipend B

☐ LCH (Lurie Children's Hospital) ☐ RIC (Rehabilitation Institute of Chicago)
☐ VA (Veteran Administration) ☐ Dept. - Division

Print Program Director Name: ______________________________________________________

Signature of Program Director: ___________________________________________ Date:_____

Signature of Funding Source Mgr.: ___________________________ Date:_____

Print Department Chair Name: ___________________________ Date:_____
Signature of Department Chair: ___________________________ Date:_____

Time-Line for Termination Submissions

☐ Completion of Training
   Submit three months before end date
   Example: June 30, (current year) submit April 1(current year)

☐ Certificate Request Form
   Submit three months before end date
   Example: June 30, (current year) submit April 1(current year)

☐ Sign-out Sheet
   Submit one week before end date
HOUSE STAFF COMPLETION OF TRAINING LIST 2016

Program:

The following house staff will satisfactorily complete their training in the above program at McGaw. This will be the last day for payroll and benefits.

Please indicate in far right columns house staff that are switching programs (residency to fellowship or another specialty within McGaw) so payroll and benefits can be continued.

<table>
<thead>
<tr>
<th>Name of Resident or Fellow</th>
<th>Completion Date:</th>
<th>Date</th>
<th>Program</th>
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Signature of Program Director

Date

Return to:
Northwestern McGaw
Center for Graduate Medical Education
420 E. Superior St., Ste. 12-176
Chicago, IL 60611
Phone: 312-503-7975  Fax: 312-503-5230
FELLOW CERTIFICATE REQUEST FORM - 2016

Name: 
First Middle Last

Present Address: ____________________________
Street Address

City State Zip

Home Phone: ____________________________ Cell: ____________________________

Forwarding Address: ____________________________
Street Address

City State Zip

Effective Date for forwarding address: ____________________________

The information required below will be printed on the certificate exactly as it appears. Please type or print legibly. There is a $20 reprint charge to correct any errors.

Full Name: ____________________________ Degree: ____________________________
First Middle Last

Fellowship Program: ____________________________

Department: ____________________________
Training Completion Date: ____________________________

Signature of Program Director ____________________________ Date ____________________________

Signature of Fellow ____________________________ Date ____________________________

Return to: McGaw Medical Center of Northwestern University
Office of Graduate Medical Education
240 East Huron Street, McGaw Pavilion, Suite 1-200
Chicago, IL 60611
Phone: 312-503-7975 Fax: 312-503-5230
 NMH SIGN-OUT SHEET FOR 2016

All portions of this sign-out sheet must be completed by housestaff prior to their last day of training. Certificates of completion will not be issued until the Office of Graduate Medical Education (240 E. Huron Street, Suite 1-200, (312) 503-7975) has received this form with appropriate signatures.

PLEASE PRINT CLEARLY

Name: ___________________________ Program ___________________________
Forwarding Home Address: ___________________________ ___________________________
                      (STREET)                      (CITY)                  (STATE)                  (ZIP)
Email: ___________________________ Home: ___________________________ Cell: ___________________________

Career Path: ___________________
          _ full time academic faculty (primary clinical)
          _ full time academic faculty (primary research)
          _ clinical practice (not primary academic)
          _ clinical practice (not primary academic but focused on underserved population)
          _ residency
          _ fellowship

Forwarding Work Address: ___________________________ Institution ___________________________
                                          Department ___________________________
                                          ___________________________ ___________________________ ___________________________ ___________________________
                                          Street                      City                     State                     Zip

It is the responsibility of the training program to verify proper sign out for the items below:

  o Medical Records ___________________________ (541 Fairbanks 14th floor-ste1475 ask for Martha Flores) (Date) _______________________________________
  o Pagers ___________________________ (Olsen 710 N. Fairbanks 7th Floor, rm 136) (Date) _______________________________________
  o Health Sciences Library ___________________________ (303 Chicago Ave, Ward 1st floor) (Date) _______________________________________
  o Remote Access Key Fob ___________________________ (251 East Huron, Feinberg 2-705) (Date) _______________________________________
  o Locker ___________________________ (Program Coordinator) (Date) _______________________________________
  o Keys ___________________________ (Program Coordinator) (Date) _______________________________________
  o I.D. Badges ___________________________ (GME or Program Coordinator) (Date) _______________________________________
  o Other ___________________________ (Date)

Departmental Clearance

Program Director/Coordinator Signature ___________________________ Date: ___________________________

McGaw Trainee Signature ___________________________ Date: ___________________________

GME Use Only
(Date of Sign Out) ___________________________ Certificate ______Yes ______No
McGaw Medical Center of Northwestern University
Office of Graduate Medical Education

LURIE CHILDREN’S - SIGN-OUT SHEET FOR 2016

All portions of this sign-out sheet must be completed by housestaff prior to their last day of training. Certificates of completion will not be issued until the Office of Graduate Medical Education (240 E. Huron Street, Suite 1-200, (312) 503-7975) has received this form with appropriate signatures.

PLEASE PRINT CLEARLY

Name: __________________________________________ Program: ___________________________

Forwarding Home Address: ________________________________

(STREET) (CITY) (STATE) (ZIP)

Email: ___________________________________________ Home: __________________________ Cell: __________________________

Career Path: ___ full time academic faculty (primary clinical)
 ___ full time academic faculty (primary research)
 ___ clinical practice (not primary academic)
 ___ clinical practice (not primary academic but focused on underserved population)
 ___ residency
 ___ fellowship

Forwarding Work Address: ____________________________ Institution __________________________

Department ____________________________

Street City State Zip

It is the responsibility of the training program to verify proper sign out for the items below:

  ○ Medical Records (HIM) ____________________________________________ (Date)
    (Manager, HIM – Room 9-111)
  ○ Pagers ____________________________________________ (Date)
    (Program Coordinator)
  ○ Health Sciences Library ____________________________ (Date)
    (Please see Carol Juevell in Room 11-230)
  ○ Remote Access Key Fob ____________________________ (Date)
    (Program Coordinator)
  ○ Keys ____________________________________________ (Date)
    (Program Coordinator)
  ○ I.D. Badges ____________________________________________ (Date)
    (Program Coordinator)
  ○ Other ____________________________________________

Departmental Clearance

Program Director/Coordinator Signature ____________________________ Date: ____________________________

McGaw Trainee Signature ____________________________ Date: ____________________________

GME Use Only
(Date of Sign Out) ____________________________ Certificate ______ Yes ______ No