



RESIDENT CLEARANCE FORM

All Residents are required to complete the clearance form when completing scheduled rotations at CHRISTUS Santa Rosa Health Care.

NAME: _____ ROTATION END DATE: _____

SPECIALTY: _____ PROGRAM DIRECTOR: _____

PLEASE CLEAR IN THE ORDER PRESENTED. EACH DEPARTMENT LISTED MUST INITIAL AND DATE AS INDICATED.

INFORMATION SERVICES

(Meditech, Email, Computer Access)
Downtown, Madeleine D Bldg., 3rd Floor, Room 3024
(210.704.2900)

INITIALS: _____ DATE: _____ N/A: _____

MEDICAL RECORDS

(Record Completions, Dictations, etc.)
Downtown, C Bldg. (210.704.2286)

INITIALS: _____ DATE: _____ N/A: _____

GRADUATE MEDICAL EDUCATION

(ID Badge, Parking hangtags, clear from system)
Center for Children's and Families (CCF) 5th Floor
(210.704.4822)

INITIALS: _____ DATE: _____ N/A: _____

_____ Pagers _____ Cellular Phone

_____ I.D. badge _____ Keys

_____ Parking tag _____ Other

Signature of Resident: _____ Date: _____