LSU Health NEW ORLEANS
School of Medicine
Department of Pediatrics

Pediatrics Graduating Fellows' Checklist

Please complete by June 30th. Scan/emailing to Kelly Allerton is acceptable.
Questions? 504-896-9800 or kslumb@lsuhsc.edu.

____ Updated GME Data Sheet (Must include all training/jobs/leaves of absence from Medical School through Fellowship.) Remember to sign each page!

____ Updated Personal Data Change form with new address. N/A if no change in address.

____ Updated CV with fellowship completion listed.

____ Fellow's non-LSU email address for future communication: _____

____ Complete ACGME Fellow Scholarly Activity form

____ Complete Exit Survey

____ Complete all duty hours in New Innovations up to fellowship completion date

____ Complete all evaluations in New Innovations

____ Complete all applicable Case/Procedure logs either in ACGME, New Innovations or a personal spreadsheet and send to Kelly

____ Complete all Core Curriculum modules on GME's website: http://www.medschool.lsuhsc.edu/medical_education/graduate/core_curriculum.aspx

____ Beeper returned to Kelly

____ Email or give Kelly the following on a flash drive (she will print for your binder):

- ____ Publications
- ____ Abstracts
- ____ Posters
- ____ Presentations at local, regional and national meetings
- ____ CME lectures given
- ____ Fellow conference presentations
- ____ Grants
- ____ QA/QI projects
- ____ SOC presentations and evaluations
- ____ Final Work Product & Personal Statement (ABP)
- ____ Anything else you can think of!

LSU Health NEW ORLEANS

GME Data Sheet

Department: _____ PS Location Code: _____

Training Program Name _____

(Check one) Residency ☐ Fellowship ☐ House Officer Level _____ Start Date _____ Expected Graduation_____

Name: _____

Mailing Address: _____

Telephone Number _____ Immigration Status: U. S. Citizen ☐ Permanent Resident ☐ J1 Visa ☐

Social Security Number _____ Citizenship: _____

Date of Birth _____ Place of Birth: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse's Name: _____

Race: ***(Please check one)***
American Native ☐ Asian or Pacific Islander ☐ Hispanic ☐ White ☐ Black ☐

List Person to Contact in case of Emergency: _____

Relationship: _____ Telephone _____

This section MUST be completed or form will be returned

EDUCATION:

College:_____ City, State: _____

Dates Attended: _____ Degree: _____

Medical School:_____City,State:_____

Dates Attended:_____Degree:_____

Dental School:_____City,State_____

Dates Attended:_____Degree:_____

FMGEM, ECFMG or NBMEE Number and Date:. _____
(please provide us with a copy of your ECFMG Certificate)

_____ _____
Signature Date

LSU Health NEW ORLEANS

Name: _____

A continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, etc., must be provided from Medical School graduation through the current internship, residency or fellowship. Explain any gaps that are longer than 1 month—use additional copies of this page if necessary.

Beginning Date **(Month/Day/Year)**: _____

End Date **(Month/Day/Year)**: _____

Position/Status: _____

Facility/Institution/Place Name: _____

City/State/Country: _____

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

_____ _____

Signature Date

PERSONAL DATA CHANGE FORM

Please use the form below to notify Human Resources of any personal data changes. Please sign, date and return the form back to:

LSU Health Sciences Center – New Orleans
Human Resources Management Department
433 Bolivar Street
New Orleans, LA 70112
Or,
Fax to 504-568-8010

Name Change: *(Please attach a copy of your social security card reflecting your new name).*

	New Information	Old Information
First Name:		
Middle Name:		
Last Name:		

Address Change:

Street Name & Number:			
City:		**State:**	
Zip code:		**Phone Number:**	

Marital Status Update:

Effective Date:		☐ Single	☐ Married	☐ Divorced

Acknowledgements:

Print Employee Name:		**Date:**	
Employee Signature:			
Employee ID:	Current Employee: *(ID Number located on back of ID badge):*	Former Employee: (*provide last 4 digits of Social Security Number):*	

HUMAN RESOURCES USE ONLY:

Agency Representative: (Agency 1904)		**Date:**	

Revised: February 2014

Fellow Scholarly Activity 2016-2017*

*Enter scholarly activity only for the current 2016-2017 academic year.
Complete all **bolded** sections.

Name:

Pub Med IDs (assigned by PubMed) for articles published in the previous academic year. List up to 3. PubMed ID (PMID) is an unique number assigned to each PubMed record. This is generally an 8 character numeric number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts.

PMID 1:

PMID 2:

PMID 3:

Number of abstracts, posters, and presentations given at international, national, or regional meetings in the 2016-2017 academic year.

Conference Presentations (#):

Number of chapters or textbooks published in the previous academic year.

Chapters/Textbooks (#):

Participated in funded or non-funded basic science or clinical outcomes research project in the previous academic year.

Participated in Research (Yes/No):

Lecture, or presentation (such as grand rounds or case presentations) of at least 30-minute duration within the sponsoring institution or program in the previous academic year.

Teaching/Presentations (Yes/No):

RESIDENT/FELLOW EXIT SURVEY

Survey should be completed for Residents/Fellows completing training in all LSU Programs. Residents/Fellows completing training June 30, or between July & June of the Fiscal Year. Residents/Fellows resigning from LSU programs during the fiscal year; Residents completing preliminary programs at LSU even if entering residency program at LSU upon completion of preliminary LSU Program.

PLEAE PRINT & Return to the Residency Coordinator in your Program.

Name: _____ **HO Level** _____

Name of LSU Residency/Fellowship Program Completing/Resigning From:

_____

DATES IN PROGRAM: **FROM:** _____ **TO**: _____

DID YOU COMPLETE THE PROGRAM: **YES** **NO**

Please let us know what your plans are after your completion or resignation from the program? (Please complete all that apply and give detailed information).

_____ **Entering another program at LSU?**
Which Program at LSU? _____

_____ **Entering another Program at a different Institution?**

Specialty Name (State if Residency or Fellowship?): _____

Institution Name: _____

Address (full address including street & number & city/state/zip): _____

_____ **Entering Private Practice, Specialty Name**: _____

Hospital/Group Name: _____

Address (full address including street & number & city/state/zip): _____

_____ **Other Employment**: Describe Other Employment: _____

Address (full address including street & number & city/state/zip: _____

_____ **Faculty Position**: Institution Name, & Department & Address (full address including street & number & city/state/zip):

_____

_____ **Research** Institution Name, Address (full address including street & number & city/state/zip):

_____

_____ **Chief Resident -**Completed Training will be Chief Resident for one year in Program listed above.

OTHER: _____ **Year Off** _____ **Unknown** _____ **Deceased**
If Unknown, put a forwarding address and phone number in "Other Employment" space above.