CEDARS-SINAI MEDICAL CENTER®

MEDICAL STUDENT CHECK OUT FORM

DATE: ____________________

PLEASE COMPLETE THIS FORM AND RETURN IT TO Sheila Yancy, in 650 West Medical Office Towers, ON YOUR LAST DAY OF SURGERY ROTATION AT CEDARS-SINAI.

NAME: ____

ROTATION DATES: ______________________________ DEPARTMENT: __SURGERY___________

ADDRESS: ____

TELEPHONE: ________________________

ITEMS	DATE RETURNED	AUTHORIZED SIGNATURE
Library	__________	___________________
Pager (If applicable)	__________	___________________
Scrubs	__________	___________________
I.D. Badge	__________	___________________
Parking Card	__________	___________________

Please list the names of all Attending Physicians, Fellows, and Residents you have worked with during this rotation:

ATTENDING PHYSICIANS: ____

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FELLOWS, RESIDENTS (not interns): ____

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Revised July 9, 2010