

Request for Waiver of Policy on Resident Compensation

Department/Program _____ Date of request _____

Name of resident applicant _____ Degree _____

Date for proposed appointment to program _____ PGY level _____

Medical school _____ Date of graduation _____

Other GME training/dates _____

Date of sanction check _____ Results _____

Date of interview for residency position _____

Names of interviewers _____

Program Director's Attestation:

I, _____, request a waiver of the Resident Compensation Policy for the above-named physician, for the following reason(s): _____

The proposed **compensation** plan is as follows: _____

Proposed **benefits** plan (equal to or greater than those provided by University Health System to other residents) (if outside plan, attach documentation): _____

Professional liability coverage (if outside plan, attach documentation): _____

Further, I verify that the evaluation and selection process for this individual has been comprehensive and has been as complete as that to which other applicants for this training program are subjected (for renewals, attach written certification that the resident is in good standing and resident's performance evaluations since last review).

Program Director

Date

Department Chair

Date

Designated Institutional Official

Date