

Policy for Education Stipends

A. Purpose:

Education stipends are monies available to residents to participate in academic endeavors that transcends the capabilities that are available at the Fargo campus to augment their own academic efforts. The purpose of this policy is to define education stipends as well as to define how these monies are to be distributed for each resident.

B. Application:

This guideline applies to all residents in the Department of Internal Medicine

C. Guidelines:

1. PGY-1 residents will receive \$100 for books, professional dues, or other academic expenses. It will not carry over to the PGY-2 or PGY-3 year.
2. PGY-2 residents beginning July 1 will have a \$1,000 stipend. This stipend is to be utilized for both their PGY-2 and PGY-3 year. They will not receive any additional monies in their PGY-3 year. He/she may decide how to use this money to enhance their medical knowledge. They may use it for meetings, texts, tapes, CD-ROMs, or dues for professional organizations.
3. Chief Residents will receive a stipend of \$500. He/she may decide how to use this money to enhance their medical knowledge. They may use it for meetings, texts, tapes, CD-ROMs, or dues for professional organizations.
4. Reimbursement will only be by check.
5. None of the monies can be used for activity following completion of the residency program.
6. None of these monies must be approved by the Program Director. The utilization must be in the academic area that is consistent with the program's goals. **THERE MUST BE A PRIOR APPROVAL. Purchases of books, attendance at meetings or any activity will generally not be funded retrospectively.**
7. Monies that are not utilized by the resident will be retained by Sanford Health.

REQUEST FOR EDUCATIONAL STIPEND

NAME: _____ **Date of Request:** _____

PROGRAM: Transitional Internal Medicine

PGY: 1 2 3

Briefly explain the purpose of the request:

Please refer to the Resident/Student Handbook for this Policy.

Fill in above information and return to the Program Coordinator.

This request must be made prior to the expense, expenses will not be directly reimbursed to the individual nor will expenses be paid after the fact.

Payment will be made by Sanford Health.

Signatures:

Program Director: _____ **Date:** _____

Approved/Not Approved

Reason:

Med. & Acad. Ed Manager: _____ **Date:** _____

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For office use only:

Balance:

Amount Paid: _____

Educational Stipend Remaining: _____

Copy made for Resident File: Y N

NOTES:

