OMB No. xxxx-xxxx
Expiration Date: xx/xx/2xx

Children's Hospitals Graduate Medical Education Payment Program
Annual Report Checklist

Name of Children's Hospital: **Address:**

City: **State:**

Zip Code: **Date of Report:**

Medicare Provider Number:

Federal fiscal year for application:

Year the hospital first received CHGME funding:

Annual Report Forms	This Column to be Completed by the Applicant Hospital	This Column to be Completed by the CHGME PP
	Is the Listed Item Completed and Attached?	
HRSA 100-1	Yes No	Yes No
HRSA 100-2	Yes No	Yes No
HRSA 100-3	Yes No	Yes No
HRSA 100-4	Yes No	Yes No
HRSA 100-5	Yes No	Yes No
Computer Disk with Zip Code Data	Yes No	Yes No
One (1) hard copy and (1) electronic copy of the completed Annual Report including relevant forms and the zip code file.	Yes No	Yes No

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