

Child and Adolescent Psychiatry Training Application Procedure

1. Please check directly with each Child and Adolescent Psychiatry (CAP) program to which you are applying to see if it is accepting the Common Application, and for any additional requirements of the individual program. Also, check whether the program prefers applications to be sent electronically or by mail.
2. Complete a copy of the Common Child & Adolescent Psychiatry Residency Application form.
3. Send the following documentation with the application:
 - a. An updated Curriculum Vita. Describe any gaps of more than one month in education or training, if applicable.
 - b. A Personal Statement (some programs may have length requirements) describing your interest in child and adolescent psychiatry and plans for future professional work.
 - c. The Attestations page.
4. Please have the Training Documentation Form completed by your current Program Director and sent directly to the CAP Training Director.
5. Request a minimum of three letters of reference (one must be from your current Program Director) from faculty who know you well. If you have been in more than one training program, please have those program directors also send letters. These letters should be sent directly to the CAP Training Director.
6. Have a copy of your Medical School Transcript and Dean's Letter sent directly to the CAP Training Director.
7. Mail (or send electronically, if appropriate) the completed application package containing the Common Child and Adolescent Psychiatry Residency Application form, Personal Statement, Attestations page, and your CV to each program to which you are applying.

Common Child & Adolescent Psychiatry Residency Application Form

Date of Application: _____ Date would start CAP training: _____

PG- level on CAP start date: _____

Full Name _____
Last
First
Middle

Present Mailing Address: _____ Permanent Mailing Address: _____

Current PG Yr. _____

Telephone: Home () _____ Work () _____ Cell () _____

Email: _____

Place of Birth _____

Legally eligible to work in USA? _____ Visa Status (if foreign national) _____

NRMP Participant Code: _____

Passed USMLE Step I _____	_____ USMLE Step II _____	
(Date)	(Score)	(Date) (Scores)
USMLE Step III _____		
(Date)	(Scores)	
Passed COMLEX _____	Level 2 _____	Level 3 _____
(for DO training)	(Date)	(Date)

ECFMG number /date _____

Board Certified? If "yes" enter name of Board and Year Certified _____

LICENSURE: State _____ Number _____ Date _____ Type _____ Expiration _____

NAMES OF REFERENCES:

Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied (one must be from your current Program Director), sent directly to the attention of the Program Director of the Child and Adolescent Psychiatry program to which you are applying. If you have been in more than one training program, please have those program directors also send letters.

1. _____ 2. _____

3. _____ 4. _____

Educational Data

Please check this box if you are attaching any additional pages

Undergraduate Education: Please provide full name and mailing address for all schools listed

Institution	Address
Attended From : _____ to _____	Degree awarded: _____

Institution	Address
Attended From : _____ to _____	Degree awarded: _____

Graduate Education (Medical and Masters or Doctoral Program)

Institution	Address
Attended From : _____ to _____	Degree awarded: _____

Institution	Address
Attended From : _____ to _____	Degree awarded: _____

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)
Address	ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No		

Residencies: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)
Address	ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No		

Fellowships: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)
Address	ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No		

Other Professional training:

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)
Address: _____		ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No	

Work Experience

Relevant Work Experience:

Research Experience and/or Interests:

Professional Presentations Yes (Please list) No

Publications Yes (Please list) No

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: **Child and Adolescent Psychiatry training program**

From: _____
(Program Director)

Residency Training Program: _____

Re: _____
Applicant

This is to verify that Dr. _____ entered our program as a PG_____ on _____ . By (date) _____ he/she will have satisfactorily completed the following training.

- _____ FTE months of primary care: internal medicine, pediatrics, family practice (4 months minimum)
- _____ FTE months of neurology (2 months minimum; one month may be child neurology)
- _____ FTE months of adult inpatient psychiatry (6 FTE months minimum)
- _____ FTE months of adult outpatient psychiatry (12 FTE months minimum, of which a minimum of 20% must be continuous experience)
- _____ FTE months of child and adolescent psychiatry (not required if resident will be completing training in child and adolescent psychiatry)
- _____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child and adolescent CL)
- _____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)
- _____ FTE months addiction psychiatry (1 month minimum, in- or outpatient)
- _____ Psychotherapy competencies

He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:

1. Date _____ 2. Date _____ 3. Date _____

He/She has had/will have experience by (date) _____ in (please check):

- community psychiatry forensic psychiatry
 emergency psychiatry ECT

The following general psychiatry requirements will NOT be completed by (date) _____

Signature of Program Director : _____

(Date)

Personal Statement

Please describe your interest in child and adolescent psychiatry and plans for future professional work.

Attestations

A. Malpractice

If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

- a. Yes No

B. Miscellaneous

- a. Has your professional license in any state ever been revoked, suspended, canceled or restricted?
 Yes No

- b. Have you ever been denied a professional license in any state? Yes No

- c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? Yes No

- d. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? Yes No

- e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason?
 Yes No

- f. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? Yes No

- g. Have you ever been convicted of a felony in a criminal action? Yes No

Important: If you answered “Yes” to any of the questions in sections A or B, please attach a written explanation on separate pages.

Applicant’s affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant: _____ Date: _____