Application Procedure

1. Please check directly with each program to which you are applying to see if they are accepting the Common Application, and for any additional requirements of the individual program.

2. Complete a copy of the Common Child & Adolescent Psychiatry Residency Application form.

3. Complete an updated Curriculum Vita. Describe any lapses of more than one month in training, if applicable.

4. Request a minimum of three letters of reference (including Program Director) and Medical School Program Evaluation/Dean’s Letter. These should be sent directly to the CAP Training Director.

5. Write a Personal Statement describing your interest in child and adolescent psychiatry and plans for future professional work. This Statement should not be more than 1,000 words, and should be submitted with your application package.

6. Please have the Training Documentation Form completed by your Program Director and sent directly to the CAP Training Director.

7. Complete the Attestations page.

8. Mail (or send electronically, if appropriate) a completed application package containing the Common Child and Adolescent Psychiatry Residency Application form, Personal Statement, Attestations page, as well as your CV to each program to which you are applying.
Common Child & Adolescent Psychiatry
Residency Application Form

Date of Application: ____________________  Beginning Year: _________________________

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: __________________________

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<th>Passed USMLE Step I</th>
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Passed COMLEX          Level 1     Level 2     Level 3     
(for DO training)     (Date)      (Date)        (Date)

ECFMG number /date ______________________________

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

LICENSURE:  State _______ Number _______ Date _______ Type _______ Expiration _______

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 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.

1. _____________________________________________  2. _____________________________________________

3. _____________________________________________  4. _____________________________________________
**Educational Data**

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

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Attended From: _______ to _______  Degree awarded: ____________________________

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Attended From: _______ to _______  Degree awarded: ____________________________

**Graduate Education** *(Medical and Masters or Doctoral Program)*

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Attended From: _______ to _______  Degree awarded: ____________________________

**Postgraduate Medical Education:**

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

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ACGME Accredited  □ Yes  □ No

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

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

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ACGME Accredited  □ Yes  □ No

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### Other Professional training:

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<th>From (Month/Day/Year)</th>
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Address: ________________________________  ACGME Accredited  □ Yes  □ No

### Work Experience

Relevant Work Experience:

---

Research Experience and/or Interests:

---

Publications/Presentations at scientific meetings  □ Yes  □ No (Please list)

---

Honors / Awards:

---

Professional Memberships:

---

Outside Interests / Achievements:
Training Documentation Form
(To be completed by the current Program Director)

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)

____ FTE months of adult outpatient psychiatry (12 FTE months, 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 C-L)

____ 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. (1,000-word limit)
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.

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 above questions, please attach a written explanation.

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:_____________________

Common Child and Adolescent Psychiatry Application 7