

Program Director's Verification Form Attesting to Child & Adolescent Psychiatry (CAP) Fellowship Eligibility

Applicant

This form is to verify that Dr. entered our program as a PGY on (month/day/year). **By the time of transfer into CAP training, s/he has satisfactorily completed and received academic credit for the following rotations:**

- months of primary care (medicine, pediatrics, family practice; 4 months FTE minimum)
- months of neurology (2 months FTE minimum; 1 may be pediatric neurology)
- months of adult inpatient psychiatry (6 months FTE minimum; 16 months maximum)
- months of continuous general outpatient psychiatry (12 months FTE, minimum 20% continuous; up to 20% may be CAP)
- months of consultation-liaison (2 months FTE minimum; 1 may be CAP)
- months of child/adolescent psychiatry (2 months FTE minimum unless going into a CAP training program)
- months of geriatric psychiatry* (1 month FTE minimum)
- months of addiction psychiatry* (1 month FTE minimum)

S/he has had experience in (please check):

- Forensic psychiatry* Community psychiatry* Emergency psychiatry*

** may be double counted from inpatient or outpatient with adequate documentation*

S/he has met (or is expected to meet) the psychotherapy competencies by the time of transfer to CAP training:

- Yes No

S/he has passed clinical skills examinations (CSEs). Please list dates:

- 1) 2) 3) Comments (optional)

Please check one of the following, as applicable:

I anticipate that after transferring to CAP training, s/he will still need to complete the following to satisfy general psychiatry training requirements:

- No outstanding requirements
- An additional year of psychiatry training to be eligible for the psychiatry ABPN exam
- To pass clinical skills examinations
- The following clinical experiences/rotations:

Dr. is currently in good standing in our program and there is no evidence of ethical or moral misconduct. To date, s/he has demonstrated competency in all core areas and competencies specified by the Psychiatry RRC of the ACGME. I anticipate s/he will leave our program on having completed months of psychiatry training and all the ACGME requirements except those stipulated above.

Psychiatry Training Director

Signature

(Name Printed)

(Date)