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: _____

Passed USMLE Step I _____ _____ USMLE Step II _____ _____
(Date) (Score) (Date) (Scores)

USMLE Step III _____ _____
(Date) (Scores)

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

_____ _____
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)

_____ ACGME Accredited ☐ Yes ☐ No
Address

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

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited ☐ Yes ☐ No
Address

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

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited ☐ Yes ☐ No
Address

Other Professional training:

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)

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)

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)

____ 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:_____