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: __________________

Passed USMLE Step I ___________ (Date) ____________ (Score) USMLE Step II ___________ (Date) _________________ (Scores)
USMLE Step III ______________ (Date) _________________ (Scores)
Passed COMLEX (for DO training) Level 1 ____________ (Date) Level 2 ______________ (Date) Level 3 _______________ (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)

Address ______________________ ACGME Accredited ☐ Yes ☐ 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 ☐ Yes ☐ 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 ☐ Yes ☐ No

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:______________________