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

_____ _____ _____ Print

Signature (Name Printed) (Date)