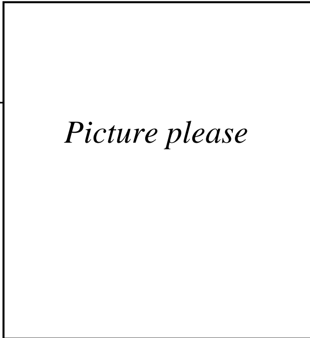
THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
"
Child and Adolescent Psychiatry
5323 Harry Hines Blvd
Dallas Texas 75390-8589

(214) 456-1383
FAX (214) 456-3640

FELLOWSHIP APPLICATION
CHILD AND ADOLESCENT PSYCHIATRY



ANTICIPATED START DATE: _______ __________ **CURRENT PGY LEVEL** ___
Month Year

If starting later than July 1, please explain on a separate page.

AAMC # ____

Name: ____
Last First Middle

Address: ____

City, State, Zip Code: ________________________________

Social Security Number: _______________ Date of Birth ______________________

E-Mail Address: _______________________________

Telephone Number: (Cell phone) ________________ (Other) ________________________

If not a U.S. citizen, do you have the legal right to remain in the U.S.? No Yes Type of Visa: ________\
Please attach a copy of your visa, naturalization card or other identification to this application.

ECFMG certificate number: ____________Expiration date: _________

USMLE: Part I No ☐ Yes ☐ Score: ____/____ Date: _________ # of Attempts: ________

Part II No ☐ Yes ☐ Score: ____/____ Date: _________ # of Attempts: ________

Part III No ☐ Yes ☐ Score: ____/____ Date: _________ # of Attempts: ________

Please note that UTSouthwestern requires passing Step III prior to acceptance into any fellowship.

Full medical license in the following state(s):
State: ____ License No: _________ Expiration date: _________
State: ____ License No: _________ Expiration date: _________
State: ____ License No: _________ Expiration date: _________
Do not include physician in training permits.

EDUCATION:
Undergraduate University: ____
Address: ____
Street City/State/Zip Code Country
Major: _________________ Grade Point Average: _________ Degree Awarded: ________________

Post Graduate University: ____

Address: ____
Street City/State/ Zip Code Country
Major: _________________ Grade Point Average: __________ Degree Awarded: ________________

Medical School: ____
Address: ____
Street City/State/ Zip Code Country

Dates of attendance: ______________________ Date of Graduation: ___________ Degree Awarded: _______

Internship or Residency Training:

Institution Name and Full Address	Degree or Specialty	# Months completed	Dates of Training (Beginning – End or In Progress)

The following questions are required.
Do you have any outstanding commitments to other programs? _____
If yes, please attach a written release from that program at the end of this application.

Has you education been interrupted for any reason other than for vacation? ______
If yes, please explain on a separate page.

Have you ever been on academic probation, administrative leave or had a disciplinary action taken against you during your training (including medical school, any post-graduate training or residency)? ______
If yes, please explain on a separate page.

If needed, use additional sheets to complete your answers to the following questions:
Honors and Awards:

Research Experience and Publications:

Community or Avocational Activities: Indicate offices held. *(You may exclude those which indicate race, creed, sex, martial status, age, color, national origin, or physical handicap.)*

Memberships in Professional Societies: *(You may exclude those which indicate race, creed, sex, martial status, age, color, national origin, or physical handicap.)*

How did you become interested in the field of psychiatry?

Why did you choose child and adolescent psychiatry as a specialty?

What are you looking for in a fellowship training program?

What has led you to be specifically interested in the fellowship at UTSW?

Do you have specific areas of interest in research?

Do you have long-term research plans?

Research Experience and Publications (if different from CV):

Letters of Reference:

Check one: ☐ *I waive access to all letters and will inform the authors.*

☐ *I do not waive access to the all letters and will inform the authors.*

____ ____

Applicant's Signature and date Name of Applicant – Type or Print

Note: The signature and date on this statement must be original.

A total of four letters are required. One letter must be from your current (or most recent) Residency Program Director. Program Director letter should include prior educational experience, including but not limited to: rotations completed, and /or evaluations of various educational experiences. The Program Director will also complete the Summative Competency form found at the end of this application.

Program Director Name and Title: ____

Institution: ____

Address: ____

Phone: ____________________________________ Email: _________________________________

Three letters of reference, in addition to the Residency Program Director's letter, are required:

Note: At least two of the three letters should be from a psychiatrist familiar with your clinical work.

Name and Title: ______________________________ Institution: _______________________________

Phone: ____________________________________ Email: _________________________________

Name and Title: ______________________________ Institution: _______________________________

Phone: ____________________________________ Email: _________________________________

Name and Title: ______________________________ Institution: _______________________________

Phone: ____________________________________ Email: _________________________________

Please arrange to have letters of recommendation sent to:

James Norcross, M.D.
Interim Director of Fellowship Training
Child and Adolescent Psychiatry
University of Texas Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas TX 75390-8589

I further authorize UTSW to contact my present/former Medical Education Director or Residency Program Director or any of the physicians with regard to my fellowship application. I further certify that the information contained in these applications is complete and correct to the best of my knowledge: I understand that any false or missing information may disqualify me for this position.

Signature of the applicant: ____ Date: _____________

Note: The signature and date on this statement must be original.

Items to be included in your application packet – please do not staple:

Photo
Completed application
Summative Competency-Based Assessment for Transfer Resident (if applicable) – form attached
Adult Requirements form - attached
CV
Personal Statement
Official undergraduate transcript(s) (if applicable)
Official post graduate transcripts (MPH, PhD, etc) (if applicable)
Official medical school transcript or certified copies
Copies of USMLE / COMLEX Step I, II, III Score Reports
Copies of Texas or Other State License (if applicable)
Copies of DEA and DPS Certificates (if applicable)
Copy of ECFMG Certificate
Copy of Visa / passport / naturalization papers, etc.
Copy medical school diploma
Three letters of reference
Letter from Training Director

All Items in the application packet should be sent to:

James Norcross, M.D.
Interim Director of Training
Child and Adolescent Psychiatry
University of Texas Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas TX 75390-8589

Please do not hesitate to contact us with any questions.

James Norcross, M.D.
Interim Director of Training
214-456-5911
James.Norcross@childrens.com

The education coordinator can be reached at: 214-456-1383.

Summative Competency-Based Assessment for Transfer Resident
In addition to the Residency Program director letter, please complete the attached form.
Thank you.

Resident Name: ____

Current PGY Level _____________ Dates of Training: ____________________

Dr. ___________________________ is currently in good standing in the __________________ (residency program) at ___________________________ (sponsoring institution). He/ She will have satisfied program goals and objectives and demonstrated competence in the six core competencies as a PGY-3:

Area	Yes	No	If No, Explain
Patient Care			
Medical Knowledge			
Interpersonal Skills and Communication			
Practice Based Learning & Improvement			
Professionalism and Ethical Behavior			
Systems-Based Practice			

Was there documented evidence of unethical behavior or unprofessional behavior?

No __________ Yes ___________ If yes, please explain on a separate page.

Will applicant have satisfactorily completed general psychiatry residency requirements by July1?

Yes __________ No ___________ If no, please explain on a separate page.

I certify the above information to be true to the best of my knowledge.

____
Signature

__________________________________ ___________________
Printed Name, Title Date

Return this form to the following address:

Paul Croarkin, D.O.
Child and Adolescent Psychiatry
5323 Harry Hines Blvd.
Dallas TX 75390-8589

Address any questions to:

Education Coordinator
214-456-1383

In addition to the Residency Program director letter, please complete this attached form. Thank you.

Re:________________________________

<Name of resident>

This is to verify that Dr. ___________________entered our program as a PGY-___ on ____________ <month/day/year>. S/he <has/ is expected to satisfactorily> complete (d) the following training as of _________<month/day/year>:

_____FTE months of primary care: internal medicine, pediatrics, family practice. (4 months min)
One month may be fulfilled by emergency medicine or intensive care.

_____ FTE months of neurology (2 months minimum)
1 month of pediatric neurology may be counted toward CAP requirement. 1 month should occur in first or second year of the program.

_____FTE months of adult inpatient psychiatry (6 months minimum, 16 months maximum)

_____FTE months of continuous adult outpatient psychiatry (12 months minimum)
No more than 20% of patients seen may be children and adolescents. This portion may be used to fulfill the 2-mo. CAP requirements so long as this component meets requirement for CAP.

_____ FTE months of child and adolescent psychiatry (2 months minimum)
Not required if resident is completing training in CAP

_____FTE months of consultation/liaison psychiatry (2 months minimum)
1 month of pediatric C/L may be counted toward CAP requirement.

_____FTE months of geriatric psychiatry (1 month minimum)

_____FTE months of addiction psychiatry (1 month minimum)*

_____ FTE months of elective rotations

S/he also has had experience in:

_____emergency psychiatry _____forensic psychiatry* _____community psychiatry*

*These experiences can be used to meet requirements in both general and child and adolescent psychiatry. (Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the 6 months, and/or as part of the outpatient requirement.)

	Clinical Skills Evaluation	**Date Completed**	**ABPN Certified Evaluator**
☐	**Number 1**	______________	______________________
☐	**Number 2**	______________	______________________
☐	**Number 3**	______________	______________________

____

Signature of Training Director Date