

Common Child & Adolescent Psychiatry Residency Application Form

Date of Application: _____ Beginning Year: _____

Full Name _____
Last First Middle

Present Mailing Address: _____ Permanent Mailing Address: _____

Social Security Number _____ Current PG Yr. _____

Telephone: Home () _____ Work () _____ Cell () _____

Email: _____

Date of Birth _____ Place of Birth _____

Citizenship _____ Visa Status (if foreign national) _____

NRMP Participant Code: _____

Passed USMLE Step I _____ (Date)	USMLE Step II _____ (Date)	USMLE Step III _____ (Date)
Passed COMLEX Level 1 _____ (for DO training) (Date)	Level 2 _____ (Date)	Level 3 _____ (Date)

Passed ECFMG Exam? _____ 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 Training Director), sent directly to the attention of the Training 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: _____

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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Professional training:

Institution	Specialty	From (Month/Day/Year)	To (Month/Day/Year)
_____	_____	_____	_____
Address: _____		ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No	

Work Experience

Relevant Work Experience:

Research Experience and/or Interests:

Publications Yes No (Please list)

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Training Documentation Form
(To be completed by the current Training Director)

Date: _____

To: Child and Adolescent Psychiatry training program

From: _____
Training Director)

Residency Training Program: _____

Re: _____
Applicant

This is to verify that Dr. _____ entered our program at a PGY ___ on _____ . By July 1, _____ 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 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 is completing training in child and adolescent psychiatry)
- _____ FTE months of consultation/liaison (2 months minimum; 1 month may be child consultation/liaison psychiatry)
- _____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)
- _____ FTE months addiction psychiatry (1 month minimum, in- or outpatient)

He/She has had/will have experience by June 30, _____ in (please check):

- community psychiatry
- forensic psychiatry
- emergency psychiatry

The following general psychiatry requirements will not be completed by June 30, _____.

Signature of Training Director or Department Chair: _____

Personal Statement
(1,000 words or less)

Malpractice / Disciplinary Actions

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. Has a mental or physical impairment lasting more than one month ever interfered with your education or professional duties within the last 10 years? Yes No
- g. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? Yes No
- h. 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: _____

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. Send an updated Curriculum Vita. Describe any lapses of more than one month in training, if applicable.
4. A minimum of three letters of reference (including Residency Training Director) and Deans Letter.
5. 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 complete the Malpractice/Disciplinary Action form, read the Applicant's affidavit, sign it and send it with your application package.
7. Please have the Training Documentation Form completed by your training director and include it with your application package.
8. Mail (or send electronically, if appropriate) a completed application package containing the Common Child and Adolescent Psychiatry Residency Application form, CV, Personal Statement, Malpractice/Disciplinary Action form with signed affidavit, and the Training Documentation Form to each program to which you are applying