NATIONWIDE CHILDREN'S
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THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

General (Adult) Program Director's Attestation Form for Child and Adolescent Psychiatry (CAP) Fellowship Eligibility

(To be completed by the current Program Director)

Applicant: _____

This is to verify that Dr. _____entered our program as a PG_____ on _____. By the time of transfer into CAP training s/he will have satisfactorily completed and received academic credit for the following rotations:

____ FTE months of primary care: medicine, pediatrics, family practice (4 months minimum)
____ FTE months of neurology (2 months minimum; 1 month may be pediatric neurology)
____ FTE months of adult inpatient psychiatry (6 months minimum; 16 months maximum)
____ FTE months of adult outpatient psychiatry (12 months; minimum 20% continuous; up to 20% may be CAP)
____ FTE months of consultation-liaison (2 months minimum; 1 may be CAP)
____ FTE months of child and adolescent psychiatry (not required if resident will be completing training in child and adolescent psychiatry)
____ FTE months of geriatric psychiatry (1 month minimum)
____ FTE months of addiction psychiatry (1 month minimum)

S/he has passed_____ Clinical Skills Verification (CSV) Evaluations. Please list dates.

1. Date_____ 2. Date_____ 3. Date _____

S/he has had/will have experiences in (please check):

[ ] community psychiatry [ ] emergency psychiatry [ ] forensic psychiatry

(Optional) Comments:
_____
_____
_____

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:
_____
_____

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Dr._____ is currently in good standing in our program and there is no evidence of ethical or moral misconduct. To dates/he has demonstrated competency in all core areas 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: _____ _____
(Name) (Date)

_____
(Signature)