GENERAL (ADULT) PROGRAM DIRECTOR'S ATTESTATION FORM FOR 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 will have 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 (or will have 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 have met) the psychotherapy competencies by the time of transfer to CAP training ☐ Yes ☐ No

S/he has passed clinical skills examinations (CSE's). Please list dates:

Dates: 1) _____ 2) _____ 3) _____

(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:

_____

_____

PLEASE GO TO SIGNATURE PAGE (OVER)

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 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) _____