

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: **Child and Adolescent Psychiatry training program**

From: _____
(Program Director)

Residency Training Program: _____

Re: _____
Applicant

This is to verify that Dr. _____ entered our program as a PG _____ on _____ . By (date) _____ 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 inpatient psychiatry (6 FTE months)

_____ 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 will be completing training in child and adolescent psychiatry)

_____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

_____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)

_____ FTE months addiction psychiatry (1 month minimum, in- or outpatient)

_____ Psychotherapy competencies

He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:

1. Date _____ 2. Date _____ 3. Date _____

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

- community psychiatry forensic psychiatry
 emergency psychiatry ECT

The following general psychiatry requirements will not be completed by (date) _____

Signature of Program Director : _____ (Date)