Training Documentation Form

(To be completed by the current Program Director)

To: Child and Adolescent Psychiatry training program Date: _____

From (Program Director Name:_____

Residency Training Program:_____

Re: _____(Applicant's Name)

This is to verify that Dr. _____entered our program as a PG_____ on _____. As of _____ he/she will have satisfactorily completed the following training:
(date)

____ 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 minimum)

____ FTE months of adult outpatient psychiatry (12 FTE months minimum, 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 and adolescent CL)

____ 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 :_____