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:

_____ 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: _______________________________________________________

Common Child and Adolescent Psychiatry Application, revised 6-16-11