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 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)

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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) _____