

TO: Meghan Morrissey
Child and Adolescent Psychiatry Residency Program Coordinator
NYU Child Study Center
577 First Avenue
New York, NY 10016

FROM:

RE:

This is to verify that Dr. _____ entered our program as a PGY-____ on _____ (mo/day/yr)

S/he will have satisfactorily completed the following training by June 30, 2011:

(Please enter the number of months completed.)

____ months of primary care: internal medicine, pediatrics, or family practice

(4 months minimum, 1 month may be emergency medicine/ICU rotation)

____ months of neurology (2 months minimum, one month may be in pediatric neurology)

____ months of adult inpatient psychiatry (6 months minimum)

____ months of adult outpatient psychiatry (12 FTE months minimum, 20% of which has to be continuous)

____ months of child and adolescent psychiatry (2 months but not required if resident is completing training in child and adolescent psychiatry)

____ months of consultation liaison (2 months minimum, one month may be in pediatric C/L psychiatry)

____ month(s) of geriatric psychiatry (1 month FTE, may be in or out patient)

____ month(s) of addiction psychiatry (1 month FTE, may be in or out patient)

Clinical Skills Verification Exams:

Number of Exams Passed: _____ (3 is expected in order to matriculate to a child and adolescent psychiatry advanced residency)

Dates of Exams: (1) _____ (2) _____ (3) _____

Age Group of Patients examined in the CSVs: (1) _____ (2) _____ (3) _____

S/he has had experience in (please check):

____ community psychiatry; ____ forensic psychiatry; ____ emergency psychiatry

Dr. _____ plans to leave our program on June 30, 2011. At that time, Dr.

 will have completed all general psychiatry program requirements.

must complete the following psychiatry training to satisfy general psychiatry program requirements:

Signature of Training Director or Chairman: _____

THIS FORM MUST BE COMPLETED AND RETURNED TO DR. SHATKIN OR APPLICANT WILL NOT BE RANKED ON MATCH LIST.