TO: Zoe Scott
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)

She/He will have satisfactorily completed the following training by June 30, 2009:

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 (9 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)

She/He has had experience in (please check):

____ community psychiatry
____ forensic psychiatry
____ emergency psychiatry

Dr.______________________ plans to leave our program on June 30, 2009. 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.

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