NYU CHILD STUDY CENTER / BELLEVUE HOSPITAL CENTER
DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY

Offers a Two-Year Fully Accredited Graduate
Training Program
in
Child and Adolescent Psychiatry
Approved by the Accreditation Council for
Graduate Medical Education for Residency
Training in Psychiatry and Child Psychiatry

APPLICATION PROCEDURE:

The formal application deadline is September 14, 2007. However, applications are accepted from qualified candidates for the two-year program until all interview slots are filled. The following material should be sent to the Training Director's office:

- Completed application form
- Curriculum Vitae
- Personal statement
- Three letters of recommendation
- Official medical school transcript and official Dean's Letter
- Copy of medical school diploma
- USMLE Certified Transcript of Scores (Steps 1, 2, & 3)
- General Psychiatry Requirements Form completed by general psychiatry Director of Residency Training (if still in training)
- Copy of graduation certificate (if completed general psychiatry training)
- Copy of ECFMG certificate (if applicable)
- Copy of current valid medical license or limited permit
- Copy of New York state license (if applicable)
- Recent photograph

Interviews are scheduled only after the above documentation has been received.

RETURN COMPLETED APPLICATION TO:

Jess P. Shatkin, MD, MPH
Director of Education and Training
Department of Child and Adolescent Psychiatry
New York University - Bellevue Hospital Center
550 First Avenue
New Bellevue 21 S 6
New York, NY 10016
(212) 263-4769
(212) 263-0202
jess.shatkin@nyumc.org

NEW YORK UNIVERSITY - BELLEVUE HOSPITAL CENTER
DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY

APPLICATION FOR RESIDENCY
IN CHILD AND ADOLESCENT PSYCHIATRY

NAME____

DATE OF APPLICATION ________________________________

ADDRESS ____

____

TELEPHONE #: (HOME)____________________(OFFICE)____________________

DATE OF BIRTH____________________SOCIAL SECURITY #______________________

MARITAL STATUS__________________CITIZENSHIP/VISA STATUS________________

DATE POSITION DESIRED_______________________

PERSONAL HEALTH_____________________________

PGY LEVEL **AS OF JULY 2008:**___________________

NAME, ADDRESS AND TEL. # OF PERSON TO CONTACT IN CASE OF EMERGENCY:

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PLEASE NOTE: **A valid New York State medical license is required for employment at New York University / Bellevue Hospital Center. You may apply to our program without a New York State medical license, but you must have a valid license and a DEA Controlled Substance Registration Certificate by July 1, 2008, or you will be unable to start the program.**

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ARE YOU LICENSED TO PRACTICE IN NEW YORK STATE?____________

LICENSE NUMBER:__________________DATE ISSUED_________________

ARE YOU LICENSED TO PRACTICE IN ANOTHER STATE?_____________

IF YES, PLEASE LIST ALL STATES IN WHICH YOU ARE LICENSED TO PRACTICE:

STATE:________________LICENSE#:___________________DATE ISSUED:__________

STATE:________________LICENSE#:___________________DATE ISSUED:__________

ARE YOU BOARD CERTIFIED IN ANY MEDICAL SPECIALTY?_______________
IF YES, PLEASE LIST ALL BOARD CERTIFICATIONS:

SPECIALTY BOARD:________________CERTIFICATE NUMBER:_____________
DATE CERTIFIED:_____________

SPECIALTY BOARD:________________CERTIFICATE NUMBER:_____________
DATE CERTIFIED:_____________

USMLE STEP 1:_______________DATE PASSED
USMLE STEP 2:_______________DATE PASSED
USMLE STEP 3:_______________DATE PASSED

UNDERGRADUATE EDUCATION:

____
name/address of college/university from which you graduated

UNDERGRADAUTE MAJOR:________________________________

DATE OF GRADUATION___________________DEGREE_____________________

MEDICAL SCHOOL:

____
name/address of medical school from which you graduated

DATE OF GRADUATION___________________DEGREE_____________________

GRADUATE EDUCATION:

____
____
name/address of any additional graduate education programs attended (e.g., masters or doctoral programs); if none, please specify.

DATE OF GRADUATION___________________DEGREE_____________________

GENERAL PSYCHIATRY RESIDENCY TRAINING PROGRAM:

____
name/address of training program

RESIDENCY DIRECTOR:____

MAY WE CONTACT YOUR RESIDENCY DIRECTOR?____________

RESIDENCY DIRECTOR CONTACT INFORMATION (please include mailing address, telephone number, and email address):____
____
____
____

ANTICIPATED DATE OF GRADUATION:_________________

ADDITIONAL POSTGRADUATE TRAINING AND EDUCATION:____________________
____
____
name/address of any additional post-graduate medical or research training; if none, please specify.

OTHER RESIDENCY (if any):____
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____

List three professional references who will send letters supporting your application. Letters of recommendation should be dated within six months of your application. (Upon acceptance into the NYU Child and Adolescent Psychiatry Program, three updated letters of reference will be required for the credentialing process.)

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MAY WE CONTACT YOUR REFERENCES DIRECTLY SHOULD WE HAVE FURTHER QUESTIONS?___________

NRMP Number:_______________

Thank you for your application!