Application Procedure

1. Please check directly with each program to which you are applying to see if they are accepting the Common Application, and for any additional requirements of the individual program.

2. Complete a copy of the Common Child & Adolescent Psychiatry Residency Application form.

3. Send an updated Curriculum Vita. Describe any lapses of more than one month in training, if applicable.

4. A minimum of three letters of reference (including Program Director) and Medical School Program Evaluation/Dean’s Letter.

5. A Personal Statement describing your interest in child and adolescent psychiatry and plans for future professional work. This Statement should not be more than 1,000 words, and should be submitted with your application package.

6. Please have the Training Documentation Form completed by your Program Director and include it with your application package.

7. Complete the Attestations page.

8. Add your Curriculum Vita to the application packet.

9. Mail (or send electronically, if appropriate) a completed application package containing the Common Child and Adolescent Psychiatry Residency Application form with Personal Statement and the Training Documentation Form, as well as your CV to each program to which you are applying.
Common Child & Adolescent Psychiatry Residency Application Form

Date of Application: ____________________  Beginning Year: ____________________

Full Name ____________________________________________________________________________

                   Last                                           First                                           Middle

Present Mailing Address:  Permanent Mailing Address:
____________________________________________________________________________________
____________________________________________________________________________________

Social Security Number ___________________________  Current PG Yr. __________________

Telephone:  Home (          ) _______________  Work (          ) _______________  Cell (          ) ____________________

Email: __________________________________________________________________________________

Date of Birth __________________  Place of Birth _________________________________________

Citizenship ___________________  Visa Status (if foreign national) __________________________

NRMP Participant Code: _______________

Passed USMLE Step I (Date)  USMLE Step II (Date) (Scores)
USMLE Step III (Date) (Scores)

Passed COMLEX Level 1 (for DO training) (Date)  Level 2 (Date)  Level 3 (Date)

ECFMG number /date __________________

Board Certified?  If "yes" enter name of Board and Year Certified ____________________________________

LICENSURE:  State ________ Number _________ Date ______________ Type ________ Expiration _______

REFERENCES:
Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied (one from your current Program Director), sent directly to the attention of the Program Director of the Child and Adolescent Psychiatry program to which you are applying.

1. ________________________________  2. ________________________________

3. ________________________________  4. ________________________________

Common Child and Adolescent Psychiatry Application
### Educational Data

**Undergraduate Education:** Please provide full name and mailing address for all schools listed

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<th>Institution</th>
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Attended From: __________ to __________

Degree awarded: __________________________ 

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Attended From: __________ to __________

Degree awarded: __________________________

**Graduate Education (Medical and Masters or Doctoral Program)**

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Degree awarded: __________________________

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Attended From: __________ to __________

Degree awarded: __________________________

**Postgraduate Medical Education:**

**Internship:** (if more than one, please provide additional information on a separate sheet)

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<th>To (Month/Day/Year)</th>
<th>ACGME Accredited</th>
<th>Yes</th>
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**Residencies:** (if more than one, please provide additional information on a separate sheet)

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**Fellowships:** (if more than one, please provide additional information on a separate sheet)

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Other Professional training:

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<td>☐ Yes ☐ No</td>
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Address: _______________________________________

Work Experience

Relevant Work Experience:

Research Experience and/or Interests:

Publications ☐ Yes ☐ No (Please list)

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:
Training Documentation Form
(To be completed by the current Program Director)

To:  Child and Adolescent Psychiatry training program

From: _____________________________________________________________

(Program Director)
Residency Training Program: _______________________________________

Re: ____________________________________________

Applicant

This is to verify that Dr. __________________________________ entered our program as a PG _____ on
________________. By (date) ________________ 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)

___ FTE months of adult outpatient psychiatry (12 FTE months, of which a minimum of 20% must be
continuous experience)

___ FTE months of child and adolescent psychiatry (not required if resident is completing training in child
and adolescent psychiatry)

___ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

___ 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 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 : ____________________________________________  (Date)
Personal Statement
Please describe your interest in child and adolescent psychiatry and plans for future professional work. (1,000-word limit)
Attestations

A. Malpractice
   If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

B. Miscellaneous
   a. Has your professional license in any state ever been revoked, suspended, canceled or restricted
      □ Yes □ No
   b. Have you ever been denied a professional license in any state? □ Yes □ No
   c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? □ Yes □ No
   d. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? □ Yes □ No
   e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason? □ Yes □ No
   f. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? □ Yes □ No
   g. Have you ever been convicted of a felony in a criminal action? □ Yes □ No

Important: If you answered “Yes” to any of the above questions, please attach a written explanation.

Applicant’s affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant: ________________________________ Date: ____________________