Child and Adolescent Psychiatry (CAP) Training
Application Instructions

1. First contact the Child and Adolescent Psychiatry (CAP) program and make sure they accept the new Common CAP Application, and ask if there are any additional requirements.

2. Complete the Common CAP Application form.

3. Send the following documentation with the application:

   a. Updated Curriculum Vita. Describe any gaps of more than one month in education or training, if applicable.

   b. Personal Statement describing your interest in child and adolescent psychiatry and plans for future professional work. (Some programs may have a page limit).

   c. Attestations page with your signature.

4. The Training Documentation Form must be completed by your current Program Director and mailed directly to the CAP Training Director.

5. Request a minimum of three letters of reference from faculty members who know you, (one letter must be from your current Program Director). If you have been in more than one training program, please have those program directors also send letters. Letters must be sent directly to the CAP Training Director.

6. A copy of your Medical School Transcript and Dean's Letter must be sent directly to the CAP Training Director.

7. Mail (or send electronically, if appropriate) the completed application package to include the Common Child and Adolescent Psychiatry Application, Personal Statement, Attestations page, and your CV.

Common Child & Adolescent Psychiatry
Fellowship Application Form

Date of Application: _____ **Anticipated Start Date** for CAP training: _____

Full Name: _____
Last **First** **Middle**

Current PG Yr: _____ **PG- level on CAP start date:** _____

Present Mailing Address: **Permanent Mailing Address:**

_____ _____

_____ _____

_____ _____

Telephone: Home: _____ Office: _____Cell: _____

Email Address: _____

Place of Birth _____ DOB: _____

Legally eligible to work in USA? _____ **Visa Status** _____
(Foreign Nationals Only)

NRMP Participant Code: _____

MDs: List USMLE dates and scores below:

USMLE **Step I** _____ _____ USMLE **Step II** _____ _____
(Date) (Score) (Date) (Score)

USMLE **Step III** _____ _____
(Date) (Score)

DOs: List COMLEX Dates and Scores below:

Level 1 _____ Level 2 _____ Level 3 _____
(Date) (Score) (Date) (Score) (Date) (Score

ECFMG Number and Date _____

Board Certification: If Board Certified, list name of Board and Year of Certification below:

_____

LICENSURE:

State _____ Number _____ Date _____ Type_____ Expiration Date _____

List NAMES OF REFERENCES: List a minimum of three names, but no more than four.
Please list the names of professionals with whom you have worked and/or studied. Have them send their letter directly to the attention of the Program Director of the Child and Adolescent Psychiatry program, (one of the letters must be from your current Program Director). If you have participated in more than one training program, please have each program director send a letter of reference.

1. _____ 3. _____

2. _____ 4. _____

Educational Data

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

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Graduate Education - (Medical and Masters or Doctoral Program)

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Postgraduate Medical Education:

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

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

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

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

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

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

OTHER Professional training:

_____

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

☐ Please check this box if you are attaching additional pages

Work Experience

Relevant Work Experience:

Explain Research Experience and/or Interests:

List Professional Presentations :

List Publications:

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 Date: _____

From (Program Director Name:_____

Residency Training Program:_____

Re: _____(Applicant's Name)

This is to verify that Dr. _____entered our program as a PG_____ on _____. As of _____ he/she will have satisfactorily completed the following training: (date)

____ 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 minimum)

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

____ FTE months of child and adolescent psychiatry (not required if resident will be completing training in child and adolescent psychiatry)

____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child and adolescent CL)

____ 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 successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:
☐ 1. Date_____ ☐ 2. Date_____ ☐ 3. Date _____

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 :_____

Personal Statement

Describe your interest in Child and Adolescent Psychiatry and explain your plans for future professional work.

Name:_____

Attestations

Circle Yes or No in response to each question below. If you answer "Yes" to any of the questions, please attach a written explanation on a separate page for each question.

Malpractice

Have you received any settlements, malpractice claims, and/or lawsuits, pending or closed, during the previous 10 years?.....Yes No

Miscellaneous

1. Has your professional license in any state ever been revoked, suspended, canceled or restricted?.....Yes No

2. Have you ever been denied a professional license in any state? .....Yes No

3. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge?.....Yes No

4. 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

5. 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

6. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? .....Yes No

7. Have you ever been convicted of a felony in a criminal action?.....Yes No

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:_____