**Applicant** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This form is to verify that Dr.      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ entered our program as a PGY       on      (month/day/year).

By the time of transfer into CAP training, she/he/they will have satisfactorily completed and received academic credit for the following rotations:

      months of primary care (4 months FTE minimum of internal medicine, pediatrics, and family medicine)

      months of neurology (2 months FTE minimum; 1 may be pediatric neurology)

      months of adult inpatient psychiatry (6 months FTE minimum; 16 months maximum)

      months of continuous general outpatient psychiatry (12 months FTE; minimum 20% continuous; up to 20% may be CAP )

      months of consultation-liaison (2 months FTE minimum; 1 may be CAP)

      months of child/adolescent psychiatry (2 months FTE minimum unless going into a CAP training program)

      months of geriatric psychiatry (1month FTE minimum)

      months of addiction psychiatry (1 month FTE minimum)

She/he/they has had (or will have had) experience in (please check)

[ ]  Forensic psychiatry\* [ ]  Community psychiatry\* [ ]  Emergency psychiatry

*\* may be double counted from inpatient or outpatient with adequate documentation*

She/he/they has met (or is expected to have met) the psychotherapy competencies by the time of transfer to CAP training [ ]  Yes [ ]  No

She/he/they has passed       clinical skills examinations (CSE's). Please list dates.

Dates: 1)      \_\_\_\_\_\_\_\_\_\_\_\_\_ 2)      \_\_\_\_\_\_\_\_\_\_\_\_\_ 3)      \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE FILL OUT SECOND PAGE/ REVERSE SIDE

Please check one of the following, as applicable:

I anticipate that after transferring to CAP training, **she/he/they will still need to complete the following to satisfy general psychiatry training requirements:**

[ ]  No outstanding requirements

[ ]  An additional year of psychiatry training to be eligible for the psychiatry ABPN exam

[ ]  To pass       clinical skills examinations

[ ]  The following clinical experiences/rotations (*Please let us know if any of these experiences are missing secondary to changes secondary to COVID’s effect on your training program*):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dr.      \_\_\_\_\_\_\_\_\_\_\_\_\_\_ is currently in good standing in our program and there is no evidence of ethical or moral misconduct. To date, she/he/they has demonstrated competency in all core areas specified by the Psychiatry RRC of the ACGME.

I anticipate she/he/they will leave our program on      \_\_\_\_\_\_\_, having completed       months of psychiatry training and all the ACGME requirements except those stipulated above.

Psychiatry Training Director       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_

 (Name) (Date)

(Signature) ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_