UCONN HEALTH

Child & Adolescent Psychiatry General Application

General Information

AAMC ID	NRMP #	USMLE ID	NBOME ID
Last Name	First Name	Middle Name	Previous Last Name/Other
Address			
Home Phone	Cell Phone	Email	
Best to contact me at: home phone, cell, email:			

Gender	Marital Status	Race	Birth Date	SSN	SIN

Birth Country	Birth City	Birth State
Citizenship	If not a US Citizen, current visa type:	If not a US Citizen, proposed visa type:

Military service obligation/deferment?	Other service obligation?
Felony Conviction?	Limitations?

Examinations

Examination	Status	Date

ACLS	PALS	DEA Reg. #	Board Certification

State Medical Licenses

Type	Number	State	Expiration Date

Medical Licensure Problems? If yes, explain:
Ever Named in a Malpractice Suit? If yes, explain:

Educational Commission for Foreign Medical Graduates Certification

Are you certified by the ECFMG?	ECFMG #:	Date of certificate:

Medical Education

Institution & Location	Dates Attended	Degree	Date of Degree
Medical Education/Training Extended or Interrupted? If yes explain:			

Medical School Honors/Awards

Membership in Honorary/Professional Societies

Education

Education	Institution & Location	Dates Attended	Degree	Field of Study
Other				
Undergraduate				

Current/Prior Training

Program	Institution & Location	Program Director	Dates attended	Years

Experience

Experience	Organization & Location	Dates attended	Supervisor	Avg. Hrs./Wk.

Publications

Language Fluency (Other than English)

Hobbies & Interests

Other Awards/Accomplishments

Certification

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program. If accepted, I understand a background check will be done.

Signature	Date

Photo

Attach: Letters of Recommendations (3)
Personal Statement
USMLEs or equivalent (Residents Step 1 and 2, Chief Residents & Fellows Step 3)

GENERAL (ADULT) PROGRAM DIRECTOR'S ATTESTATION FORM FOR CHILD & ADOLESCENT PSYCHIATRY (CAP) FELLOWSHIP ELIGIBILITY

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, s/he will have satisfactorily completed and received academic credit for the following rotations:

_____months of primary care (medicine, pediatrics, family practice; 4 months FTE minimum)

_____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 (1 month FTE minimum)

_____months of addiction psychiatry (1 month FTE minimum)

S/he 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*

S/he has met (or is expected to have met) the psychotherapy competencies by the time of transfer to CAP training ☐ Yes ☐ No

S/he has passed _____ clinical skills examinations (CSE's). Please list dates.
Dates: 1) _____ 2) _____ 3) _____
(Optional) Comments: _____
_____
_____
_____

Please check one of the following, as applicable:
I anticipate that after transferring to CAP training, **s/he 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 GO TO SIGNATURE PAGE (OVER)

Dr. _____ is currently in good standing in our program and there is no evidence of ethical or moral misconduct. To date, s/he has demonstrated competency in all core areas specified by the Psychiatry RRC of the ACGME.
I anticipate s/he 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) _____

UCONN | SCHOOL OF MEDICINE

GRADUATE MEDICAL EDUCATION

Verification of Prior Residency/Fellowship Training

Name: _____
(Last name, First name)

Name of Institution: _____

Name of Program: _____

Dates of Training: _____*

PGY Levels _____ Completed Program ☐ yes ☐ no*

ACGME or equivalent accreditation of program	☐ yes	☐ no
Credit for all months of training at each level	☐ yes	☐ no*
Probation	☐ yes*	☐ no

Satisfactory performance:

Patient Care	☐ yes	☐ no*
Medical Knowledge	☐ yes	☐ no*
Interpersonal Skills & Communication	☐ yes	☐ no*
Professionalism	☐ yes	☐ no*
Systems Based Practice	☐ yes	☐ no*
Practice Based Learning	☐ yes	☐ no*

At any time during training, was any competency below satisfaction? ☐ yes* ☐ no

Please explain any [*] answers here:

_____ _____
Program Director or GME Administrator/Dean Signature Date

_____
Printed Name and Title

_____ Institutional Seal
Institution

_____
Address

UCONN HEALTH

Department of Psychiatry
Child & Adolescent Psychiatry Division

PERMISSION TO CONTACT REFERENCES
TO BE COMPLETED BY APPLICANT

Dear Training Director:

I give permission to the Child & Adolescent Psychiatry Residency program at the University of Connecticut Health Center, School of Medicine to contact my Training Director as well as the other individuals who have provided letters of recommendation at my request.

_____ _____
Applicant's name (printed) Date

_____ _____
Applicant's Signature Date

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_____ _____
Training Director (reference # 1) Phone number

_____ _____
Reference # 2 Phone number

_____ _____
Reference # 3 Phone number
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UCONN HEALTH

Department of Psychiatry
Child & Adolescent Psychiatry Division

Please submit the following documentation with your application:

1. Application
2. Curriculum Vitae

   Please cover all months since graduating from medical school. Explain any time gaps in your training or work in a separate letter.

3. Letters of Reference (3 required)

   One letter must be from your current Training Director. The two additional letters must be from faculty you have worked with

4. Personal Statement
5. Proof of USMLE scores
6. Letter attesting to General Psychiatry Board Eligibility
7. Verification of prior residency form
8. Proof of ECFMG
9. Proof of Citizenship
10. Permission to Contact References form

    Please date and sign the letter giving our program permission to contact your references.

11. Medical School Transcript
12. Medical School Dean's Letter