GENERAL (ADULT) PROGRAM DIRECTOR'S ATTESTATION FORM
FOR CHILD & ADOLESCENT PSYCHIATRY (CAP) FELLOWSHIP ELIGIBILITY
(revised summer 2020)

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 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) _____