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 (1 month 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: ______________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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):

_________________________________________________________________

____________________________________________________________________

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) ________________________________