Documentation of General Psychiatry Training

This verifies that Dr. __________________________ entered our program as a PGY _____ on __________ (mo/da/yr), and has satisfactorily completed or will complete by the end of this academic year the following training:

____ months primary care (internal medicine, pediatrics or family practice - 4 months minimum)
____ months neurology (2 months minimum)
____ months adult inpatient psychiatry, or the equivalent experience (9 months minimum)
____ months continuous adult outpatient psychiatry (12 months FTE minimum)
____ months adult consultation liaison psychiatry (2 months minimum; child/adolescent C/L can substitute 1 month)
____ months geriatric psychiatry (1 month minimum)
____ months addiction psychiatry (1 month minimum)

S/He has had experience in (please check):

__ community psychiatry __ emergency psychiatry
__ forensic psychiatry
__ child/adolescent psychiatry

S/He left or will be leaving our program on _______ (mo/da/yr) in good standing.

S/He must complete the following psychiatry training to satisfy adult training requirements (if applicable):

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

__________________________________________________________
Signature of Training Director     Date

THIS FORM MUST BE COMPLETED AND RETURNED OR APPLICANT WILL NOT BE RANKED ON MATCH LIST