



CEDARS-SINAI MEDICAL CENTER®

Child & Adolescent Psychiatry Fellowship

1. Complete a copy of the following Child & Adolescent Psychiatry Fellowship Application form. All forms must be filled out completely and legibly.
2. Complete an updated Curriculum Vita, updated to include your current Residency. Describe any lapses of more than one month in training, if applicable. Please also include a current photograph of yourself.
3. Request a minimum of two letters of reference. As well as from your Medical School Program Evaluation/Dean's Letter and one from your Program Director.
4. Write a Personal Statement describing your interest in child and adolescent psychiatry and plans for future professional work. This Statement should not be more than 1,000 words, and should be submitted with your application package.
5. **Please have the Training Documentation Form (page 5 of this application) completed by your Program Director and sent directly to us.**
6. Complete the Attestations page and return it with your application.
7. Mail a completed application package containing the Common Child and Adolescent Psychiatry Residency Application form, Personal Statement, Attestations page, as well as your CV and any other supporting documents. Please note that your application packet (and all pertinent documents) must be received in our office no later than October 1st.

Common Child & Adolescent Psychiatry Fellowship Application Form

Date of Application: _____ Beginning Year: _____

Full Name _____
Last First Middle

Present Mailing Address: _____ Permanent Mailing Address: _____

Current PG Yr. _____

Telephone: Home _____ Work _____ Cell _____
(including area code)

Email: _____

Place of Birth _____

Legally eligible to work in USA? _____ Visa Status (if foreign national) _____

NRMP Participant Code: _____

Passed USMLE Step I _____ (Date) (Score)	USMLE Step II _____ (Date) (Score)
USMLE Step III _____ (Date) (Score)	
Passed COMLEX Level 1 _____ Level 2 _____ Level 3 _____ (for DO training) (Date) (Date) (Date)	

ECFMG number /date _____

Board Certified? If "yes" enter name of Board and Year Certified _____

LICENSURE: State _____ Number _____ Date _____ Type _____
Expiration _____ (i.e. MD, DO)

REFERENCES:

Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied (one from your current Program Director), sent directly to the attention of the Program Director.

1. _____ 2. _____

3. _____ 4. _____

Educational Data

Undergraduate Education: Please provide full name and mailing address for all schools listed

Institution	Address
Attended From _____ to _____	Degree awarded: _____

Institution	Address
Attended From _____ to _____	Degree awarded: _____

Graduate Education (Medical and Masters or Doctoral Program)

Institution	Address
Attended From _____ to _____	Degree awarded: _____

Institution	Address
Attended From _____ to _____	Degree awarded: _____

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year) To (Month/Day/Year)
Address _____		ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No

Residencies: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year) To (Month/Day/Year)
Address _____		ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No

Fellowships: (if more than one, please provide additional information on a separate sheet)

Institution	Specialty	From (Month/Day/Year) To (Month/Day/Year)
Address _____		ACGME Accredited <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Professional training:

Institution	Specialty	From (Month/Day/Year) To (Month/Day/Year)
<hr/>	<hr/>	<hr/>

ACGME Accredited Yes No

Address

Work Experience

Relevant Work Experience:

Research Experience and/or Interests:

Publications/Presentations at scientific meetings Yes No (Please list)

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: Cedars Sinai Child and Adolescent Psychiatry training program

From: _____
(Program Director)

Residency Training Program: _____

Re: _____
Applicant

This is to verify that Dr. _____ entered our program as a PG _____ on _____. By (date) _____ he/she will have satisfactorily completed the following training.

_____ FTE months of primary care: internal medicine, pediatrics, family practice (4 months minimum)

_____ FTE months of neurology (2 months minimum; one month may be child neurology)

_____ FTE months of adult inpatient psychiatry (6 FTE months)

_____ FTE months of adult outpatient psychiatry (12 FTE months, of which a minimum of 20% must be continuous experience)

_____ FTE months of child and adolescent psychiatry (not required if resident will be completing training in child and adolescent psychiatry)

_____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

_____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)

_____ FTE months addiction psychiatry (1 month minimum, in- or outpatient)

_____ Psychotherapy competencies

He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:

1. Date _____ 2. Date _____ 3. Date _____

He/She has had/will have experience by (date) _____ in (please check):

- community psychiatry forensic psychiatry
 emergency psychiatry ECT

The following general psychiatry requirements will not be completed by (date) _____

Signature of Program Director : _____ (Date) _____

Personal Statement

Please describe your interest in child and adolescent psychiatry and plans for future professional work. (1,000-word limit)

Attestations

A. Malpractice

If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

B. Miscellaneous

- a. Has your professional license in any state ever been revoked, suspended, canceled or restricted Yes No
- b. Have you ever been denied a professional license in any state? Yes No
- c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? Yes No
- d. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? Yes No
- e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason? Yes No
- f. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? Yes No
- g. Have you ever been convicted of a felony in a criminal action? Yes No

Important: If you answered “Yes” to any of the above questions, please attach a written explanation.

Applicant’s affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant: _____ Date: _____