

# Sample Child Neurology Letter

<on letterhead>

<date>

Program ID: \_\_\_\_\_

Larry R. Faulkner, M.D.  
President and CEO  
American Board of Psychiatry and Neurology  
2150 East Lake Cook Road, Suite 900  
Buffalo Grove, IL 60089

Re: <Name of resident>

Dear Dr. Faulkner:

This is to verify that Dr. <Name> entered our child neurology residency program as a PGY-<year> on <month/day/year>. S/he <has/will satisfactorily> complete(d) the following training:

\_\_\_\_\_ FTE months of clinical child neurology (12 months minimum)

\_\_\_\_\_ FTE months of clinical adult neurology (12 months minimum)

\_\_\_\_\_ FTE months of outpatient clinical child neurology (4 months minimum included in 12 months above. Must also include a longitudinal/continuity clinic ½ day weekly throughout the program)

\_\_\_\_\_ FTE months of management of children and adolescents with psychiatric disorders under the supervision of a qualified child and adolescent psychiatrist (1 month minimum)

\_\_\_\_\_ FTE months of training in the basic and related sciences (2 months minimum)

\_\_\_\_\_ FTE months of electives (3 months minimum)

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<u>Clinical Skills Evaluations</u>	<u>Date Completed:</u>	ABPN Certified Evaluator:
<input type="checkbox"/> Adult Neurology	_____	_____
<input type="checkbox"/> Critical Care	_____	_____
<input type="checkbox"/> Neuromuscular	_____	_____
<input type="checkbox"/> Ambulatory (headache, seizure)	_____	_____
<input type="checkbox"/> Neurodegenerative (movement, inflammatory)	_____	_____

Dr. <Name> has demonstrated sufficient professional ability to practice competently and independently. There is no evidence of unethical behavior, unprofessional behavior, or clinical incompetence.

Dr. <Name> <left/successfully completed/will complete> the program on <month/day/year>.

Sincerely,

<Name, MD>  
Child Neurology Residency Director