

SAMPLE GENERAL PSYCHIATRY 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 program as a PGY-<year> on <month/day/year>. S/he <has/ is expected to satisfactorily> complete(d) the following training as of <month/day/year>:

_____ FTE months of primary care: internal medicine, pediatrics, family practice. (4 months minimum)
One month may be fulfilled by emergency medicine or intensive care.

_____ FTE months of neurology (2 months minimum.) 1 month of pediatric neurology may be counted toward CAP requirement. One month should occur in first or second year of the program.

_____ FTE months of adult inpatient psychiatry (6 months minimum, 16 months maximum)

_____ FTE months of continuous adult outpatient psychiatry (12 months minimum)
No more than 20% of patients seen may be children and adolescents. This portion may be used to fulfill the 2-mo. CAP requirements so long as this component meets requirement for CAP.

_____ FTE months of child and adolescent psychiatry (2 months minimum. Not required if resident is completing training in CAP)

_____ FTE months of consultation/liaison psychiatry (2 months minimum.) 1 month of pediatric C/L may be counted toward CAP requirement.

_____ FTE months of geriatric psychiatry (1 month minimum)

_____ FTE months of addiction psychiatry (1 month minimum)*

_____ FTE months of elective rotations.

S/he also has had experience in:

_____ emergency psychiatry _____ forensic psychiatry* _____ community psychiatry*

*These experiences can be used to meet requirements in both general and child and adolescent psychiatry. (Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the 6 months, and/or as part of the outpatient requirement.)

<u>Clinical Skills</u>	<u>Date Completed:</u>	<u>ABPN Certified</u>
<u>Evaluation</u>		<u>Evaluator:</u>
<input type="checkbox"/> Number 1	_____	_____
<input type="checkbox"/> Number 2	_____	_____
<input type="checkbox"/> Number 3	_____	_____

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 the program/successfully completed/will complete the program on month/day/year.

Sincerely,
Psychiatry Program Director