

SAMPLE LETTER FOR RESIDENTS TRANSFERRING TO CAP

<On letterhead>

<date>

Program ID: _____

<CAP Program Director>

<address>

Re: <Name of resident>

Dear Dr. <CAP Program Director>:

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

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

_____ FTE months of continuous adult outpatient psychiatry (12 months minimum)

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

_____ FTE months of consultation/liaison psychiatry (2 months minimum. 1 month may be in child consultation/liaison psychiatry)

_____ 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:

_____ community psychiatry

_____ forensic psychiatry

_____ emergency psychiatry

Clinical Skills

Evaluation

Date Completed:

ABPN Certified

Evaluator:

Number 1

Number 2

Number 3

Community psychiatry experience and forensic psychiatry experience may be completed during child and adolescent psychiatry training.

Dr. <Name> transferred to <program> child and adolescent psychiatry program on <month/day/year>. The following general psychiatry requirements have not been met:

Sincerely,

<name, MD>

Psychiatry Residency Director