CHILD & ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM

APPLICATION PROCESS

Applications are accepted from July 15 – October 31, 2011. Applications are reviewed upon completion, so early submission is strongly recommended. Interviews are offered to qualified applicants on Tuesdays, from September 13 through November 29, 2011.

The following materials are required:

- ✉ Completed NYPH Child and Adolescent Psychiatry Residency Training Application
- 🖹 Non–U.S. Citizens Must Submit Proof of Visa Status *(B Visas unacceptable)*
- Completed NYPH Training Documentation Form *
- ✉ Current CV
- ✉ Personal Statement
- Three Letters of Recommendation *(one **must** be from current training director)* *
- Medical-School Transcript and Dean's Letter *(an official copy)* *
- 🖹 Copy of Medical-School Diploma
- 🖹 Copy of your M.D. or D.O. License
- 🖹 Foreign-Medical-School Graduates Must Submit a Copy of Their ECFMG Certificate
- USMLE or COMLEX scores, steps 1, 2, and 3 *(official certified transcript of scores)* *

✉ Required to submit electronically to:

Jewel Williams, Program Coordinator at williamj@childpsych.columbia.edu

🖹 *Please know it is acceptable to also electronically submit scanned copies of your proof of Visa status, your medical school diploma/ECGMG and your M.D. or D.O. license.*

* **Originals** of all other application materials must be sent **by the originator** directly to:

Dr. Elisabeth Guthrie, Director
NYPH Child & Adolescent Psychiatry Residency Training Program
New York State Psychiatric Institute
1051 Riverside Drive, Unit 78
New York, NY 10032

PLEASE DO NOT STAPLE PAGES WHEN MAILING APPLICATION MATERIALS !

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

CHILD & ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM

APPLICATION

(Please type or print)

Name: ____
Last Name First Name Middle Initial

Social Security Number: _____-____-_____ Date of Birth: ____-____-______ Sex: ☐ Male ☐ Female

Work Address: Institution:____

____
Number Street City State Zip Code

Work Telephone: ______________________________ Work Fax Number: ________________________

Home Address:

____
Number Street Apt # City State Zip Code

Home Telephone: ____________________ Cell Phone: ____

Email Address: ____

AAMC
ID No.________________________________

National Provider
Identifier ("NPI")________________________________

Federal Drug Enforcement Administration ("DEA") Number________________Expiration Date_____________

USMLE (or COMLEX Level I, II, and III if a graduate of an Osteopathic College)
*If you have not yet taken the STEP III exam (or COMLEX Level III), please indicate scheduled test date in parentheses. No applicant may be accepted into the program who has not passed STEP I, II, and III (or COMLEX Level I, II, and III).

USMLE STEP I: Date:___________ USMLE STEP II: Date:_____________ USMLE STEP III: Date:______________

New York State License Number:__________________ Date of Issuance: __________ Expiration:___________

(If licensed in another state) State:___________License No.______________________Expiration:___________

Citizenship:___________________________________If non-U.S. citizen, type and status of visa:____________

Effective date of visa: from_____________________________ to____________________________________

ECFMG No.:_______________ Date Issued:____________ ☐ Permanent ☐ Temporary, expires ____________

EDUCATIONAL DATA

Undergraduate Education: Please provide full name, mailing address, degree awarded and exact attendance dates, including the month, day and year) for all schools listed:

Institution ______ Address ______

Attended: from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Degree awarded: ______

Institution ______ Address ______

Attended: from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Degree awarded: ______

Graduate Education (Medical or Doctoral Program)

Institution ______ Address ______

Attended: from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Degree awarded: ______

Institution ______ Address ______

Attended: from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Degree awarded: ______

Postgraduate Medical Education: Please provide the following information for all training begun or completed (internships, residencies, and fellowships).

Internship (If more than one internship, please provide the same information on a separate sheet)

Institution | Specialty | From (Month/Day/Year) | To (Month/Day/Year)

______ ACGME Accredited? ☐ Yes ☐ No

Complete Address

Residencies (If more than two residencies please provide the same information on a separate sheet)

Institution | Specialty | From (Month/Day/Year) | To (Month/Day/Year)

______ ACGME Accredited? ☐ Yes ☐ No

Complete Address

Institution | Specialty | From (Month/Day/Year) | To (Month/Day/Year)

______ ACGME Accredited? ☐ Yes ☐ No

Complete Address

Fellowship (If more than one fellowship, please provide the same information on a separate sheet)

Institution | Specialty | From (Month/Day/Year) | To (Month/Day/Year)

______ ACGME Accredited? ☐ Yes ☐ No

Complete Address

SERVICE OBLIGATIONS *(National Health Service Corps, Armed Services Scholarship, State Program, Etc.)*

- ☐ I am not required to fulfill any service obligations
- ☐ I am committed to fulfill a service obligation beginning:_____________________________Number of years:______

AMERICAN SPECIALTY BOARD STATUS *(if any)*

Name of board: ______________________________________ Date of certification/recertification:____________________

HEALTH STATUS

Do you currently have any mental or physical condition that would adversely affect any of the following:

	NO	YES
Your ability to perform any of the essential functions of your responsibilities?	☐	☐
Your ability to perform the essential functions required by the clinical privileges you are requesting?	☐	☐
Your ability to perform the essential functions required by the participation status you are requesting?	☐	☐
Are you habituated or addicted to depressants, stimulants, narcotics, alcohol or drugs or any substances that might alter behavior?	☐	☐

If the answer to any of the foregoing questions is YES, please provide a full explanation on a separate sheet and attach.

PROFESSIONAL CONDUCT

	NO	YES
Have you ever been convicted of a crime (other than a minor traffic offense), or are there any criminal charges pending against you (other than for minor traffic offenses)?	☐	☐
Have you ever been found guilty of professional misconduct as defined by the laws of New York State or any other jurisdiction?	☐	☐
Are any professional misconduct proceedings pending against you in any state or jurisdiction?	☐	☐
Have proceedings ever been instituted against you, or are there any proceedings currently pending by any state to have your license to practice suspended, revoked, terminated, limited, denied, not renewed, or subject to probationary status, either voluntarily or involuntarily?	☐	☐
Have proceedings ever been instituted against you or are there any proceedings currently pending to have your DEA license or any other state-controlled substance authorization denied, not renewed, revoked, reduced, suspended, or otherwise limited, either voluntarily or involuntarily?	☐	☐

PROFESSIONAL CONDUCT (continued)

	NO	YES
Has your participation in any internship, residency, or other training program ever been suspended, restricted, or terminated prior to completion, or have you been denied certification of completion of training in such a program, or have you ever voluntarily or involuntarily relinquished participation in such a program?	☐	☐
Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, judgments, or arbitration proceedings involving your professional practice in this state or any other? (If yes, please attach an explanation.)	☐	☐
Have any of the following ever been voluntarily or involuntarily limited, suspended, revoked, denied, reduced, relinquished, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official, committee, or governing board, or are any such proceedings or recommendations currently in process or pending:		
Medical staff membership or employment status at any other hospital	☐	☐
Clinical privileges at any hospital or health care institution	☐	☐
Academic appointment or appointment status at any health care institution or university	☐	☐
Professional society membership or fellowship	☐	☐
Have you ever been denied professional liability insurance or coverage, or has your policy ever been canceled or denied renewal for reasons other than non-payment of premium, such as claims experience?	☐	☐
Have you ever had sanctions imposed, or are there currently sanction proceedings pending to deny, reprimand, censure, exclude, suspend (even if the suspension was stayed), limit, or disqualify you from participating in Medicare, Medicaid, or any other third-party-reimbursement program for medical services?	☐	☐
Have you ever been denied participation in the network of a managed-care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization?	☐	☐
Have you ever been found guilty of violations of patients' rights?	☐	☐

If the answer to any of the foregoing questions is YES, please provide a full explanation on a separate sheet, including resolution of charges.

INTERVIEW SCHEDULE

Interviews are offered upon review of completed applications by the residency selection committee and are not guaranteed. Interviews are scheduled on Tuesdays, from September 13 through November 29, 2011.

☐ The following general time period is most convenient for me: from ________________ to ________________

☐ I am able to schedule an interview on the following specific dates:

______________________	______________________	______________________	______________________
Date	Date	Date	Date

REFERENCES

The applicant is requested to arrange for the three letters of recommendation to be sent directly to Elisabeth Guthrie, M.D., Director, NYPH Child and Adolescent Psychiatry Residency Training Program, 1051 Riverside Drive, Unit 78, New York, NY 10032-2626.

Name	Address
1. ________________________	____
2. ________________________	____
3. ________________________	____

Check One

☐ I hereby waive access to the above letters and will so inform the authors.

☐ I desire access to the above letters and will so inform the authors.

____ ______________________________

Signature Date

____

Name of applicant (type or print)