








CHILD & ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM

APPLICATION PROCESS


Applications are accepted from August 1 – October 30, 2009. Applications are reviewed upon completion, so early submission is strongly recommended. Interviews are offered to qualified applicants on Tuesdays, from September 15 through December 1, 2009.

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/ECFMG and your M.D. or D.O. license.*

*** Originals of all other application materials should be addressed 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

CHILD & ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM

APPLICATION

(Please type or print)

Name: _____
Last Name First Name Middle Initial

Social Security Number: _____ - _____ - _____ 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 (i.e. month-day-year) for all schools listed:

Institution Address
Attended: from _____ to _____ Degree awarded: _____

Institution Address
Attended: from _____ to _____ Degree awarded: _____

Graduate Education (Medical or Doctoral Program)

Institution Address
Attended: from _____ to _____ Degree awarded: _____

Institution Address
Attended: from _____ to _____ 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?	<input type="checkbox"/>	<input type="checkbox"/>
Your ability to perform the essential functions required by the clinical privileges you are requesting?	<input type="checkbox"/>	<input type="checkbox"/>
Your ability to perform the essential functions required by the participation status you are requesting?	<input type="checkbox"/>	<input type="checkbox"/>
Are you habituated or addicted to depressants, stimulants, narcotics, alcohol or drugs or any substances that might alter behavior?	<input type="checkbox"/>	<input type="checkbox"/>

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)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been found guilty of professional misconduct as defined by the laws of New York State or any other jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
Are any professional misconduct proceedings pending against you in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
Clinical privileges at any hospital or health care institution	<input type="checkbox"/>	<input type="checkbox"/>
Academic appointment or appointment status at any health care institution or university	<input type="checkbox"/>	<input type="checkbox"/>
Professional society membership or fellowship	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been found guilty of violations of patients' rights?	<input type="checkbox"/>	<input type="checkbox"/>
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 16 through December 9, 2008.

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)

CHILD & ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM

TRAINING DOCUMENTATION FORM

TO: Elisabeth Guthrie, M.D., Director
NYPH Child and Adolescent Psychiatry Residency Training Program
1051 Riverside Drive, Unit 78
New York, NY 10032-2626

FROM: _____
Training Director

RE: _____
Applicant

This is to verify that Dr. _____ entered our program as a PGY-_____ on _____. By July 1, 2010, he/she will be a PGY-_____ and 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 (9 months minimum, 18 months maximum).

_____ 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 is completing training in child and adolescent psychiatry).

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

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

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

By June 30, 2010 he/she will have experience in (please check):

community psychiatry forensic psychiatry emergency psychiatry

The following general psychiatry requirements will not be completed by June 30, 2010:

Signature of Training Director or Chairman

Please clearly print name and title of signee