TO: Bridget Hayde, M.S.
Child and Adolescent Psychiatry Residency Program Coordinator
NYU Child Study Center
One Park Avenue
New York, NY 10016

FROM:

Re:

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This is to verify that Dr.______________ entered our program as a PGY-____ on _____________ (mo/day/yr)

S/he will have satisfactorily completed the following training by June 30, 2018:
(Please enter the number of months completed.)

____ months of primary care: internal medicine, pediatrics, or family practice
   (4 months minimum, 1 month may be emergency medicine/ICU rotation)
____ months of neurology (2 months minimum, one month may be in pediatric neurology)
____ months of adult inpatient psychiatry (6 months minimum)
____ months of adult outpatient psychiatry (12 FTE months minimum, 20% of which has to be continuous)
____ months of child and adolescent psychiatry (2 months but not required if resident is completing training in
   child and adolescent psychiatry)
____ months of consultation liaison (2 months minimum, one month may be in pediatric C/L psychiatry)
____ month(s) of geriatric psychiatry (1 month FTE, may be in or out patient)
____ month(s) of addiction psychiatry (1 month FTE, may be in or out patient)

Clinical Skills Verification Exams:

Number of Exams Passed:___________________ (3 is expected in order to matriculate to a child and adolescent
psychiatry advanced residency)

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<tr>
<th>Date Passed</th>
<th>ABPN Certified Evaluator</th>
<th>Age of Patient</th>
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S/he has had experience in (please check):
____ community psychiatry; ____ forensic psychiatry; ____ emergency psychiatry

Dr.______________ plans to leave our program on__________. At that time, Dr. ______________
[ ] will have completed all general psychiatry program requirements.
[ ] must complete the following psychiatry training to satisfy general psychiatry program requirements:
   ____________________________________________
   ____________________________________________
   ____________________________________________

Signature of Training Director or Chairman: __________________________ Date ____________

THIS FORM MUST BE COMPLETED AND RETURNED TO NYU OR APPLICANT WILL NOT BE RANKED
ON MATCH LIST.