University of Connecticut School of Medicine
Child & Adolescent Psychiatry Residency/Fellowship
Common Application Form

General Information

AAMC ID	NRMP #	USMLE ID	NBOME ID
Last Name	First Name	Middle Name	Previous Last Name/Other
Address			
Home Phone	Cell Phone	Email	
Best to contact me at: home phone, cell, email:			

Gender	Marital Status	Race	Birth Date	SSN	SIN

Birth Country	Birth City	Birth State
Citizenship	If not a US Citizen, current visa type:	If not a US Citizen, proposed visa type:

Military service obligation/deferment?	Other service obligation?
Felony Conviction?	Limitations?

Examinations

Examination	Status	Date

ACLS	PALS	DEA Reg. #	Board Certification

State Medical Licenses

Type	Number	State	Expiration Date

Medical Licensure Problems? If yes, explain:
Ever Named in a Malpractice Suit? If yes, explain:

Educational Commission for Foreign Medical Graduates Certification

Are you certified by the ECFMG?	ECFMG #:	Date of certificate:

Medical Education

Institution & Location	Dates Attended	Degree	Date of Degree
Medical Education/Training Extended or Interrupted? If yes explain:			

Medical School Honors/Awards

Membership in Honorary/Professional Societies

Education

Education	Institution & Location	Dates Attended	Degree	Field of Study
Other				
Undergraduate				

Current/Prior Training

Program	Institution & Location	Program Director	Dates attended	Years

Experience

Experience	Organization & Location	Dates attended	Supervisor	Avg. Hrs./Wk.

Publications

Language Fluency (Other than English)

Hobbies & Interests

Other Awards/Accomplishments

Certification

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program. If accepted, I understand a background check will be done.

Signature	Date

Photo

Attach: Letters of Recommendations (3)
Personal Statement
USMLEs or equivalent (Residents Step 1 and 2, Chief Residents & Fellows Step 3)

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: Child and Adolescent Psychiatry training program

From: _____
(Program Director)

Residency Training Program:_____

Re: (Applicant) _____

This is to verify that Dr. _____entered our program as a PG_____ on _____. By (date) _____ he/she 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 (6 FTE months)

____ 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 will be completing training in child and adolescent psychiatry)

____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)

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

____ Psychotherapy competencies

He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:

1. Date_____ 2. Date_____ 3. Date _____

He/She has had/will have experience by (date) _____ in (please check):

☐ community psychiatry ☐ forensic psychiatry
☐ emergency psychiatry ☐ ECT

The following general psychiatry requirements will not be completed by (date) _____
_____

Signature of Program Director: _____ _____
(Date)

Please return completed form to: Daniel F. Connor, MD
Training Director of Child and Adolescent Psychiatry
University of Connecticut Health Center
263 Farmington Avenue
Farmington, CT 06030-1410

Telephone: (860) 679-2730 Fax: (860) 679-1296 Email: dconnor@ uchc.edu

University of Connecticut Health Center
School of Medicine

VERIFICATION OF PRIOR RESIDENCY/FELLOWSHIP TRAINING

Name:_____
(Last Name, First Name; type/print clearly)

The above named physician was a resident or fellow in:

Name of Program: _____

Dates of Training: _____*

PGY levels _____ Completed Program ___yes ___no*

ACGME or Equivalent accreditation of program _____yes _____no

Credit for all months of training at each level _____yes _____no*

Probation _____yes* _____no

Satisfactory performance at all levels of training in:

Patient Care	____yes	____no*
Medical Knowledge	____yes	____no*
Interpersonal Skills & Communication	____yes	____no*
Professionalism	____yes	____no*
Systems Based Practice	____yes	____no*
Practice Based Learning	____yes	____no*

_____ _____
Program Director or GME Administrator/Dean Signature Date

_____
Printed Name and Title

Institutional Seal

_____
Institution

_____
Address

* Please explain on reverse side any breaks in training or * responses

An Equal Opportunity Employer

263 Farmington Avenue
Farmington, Connecticut 06030

University of Connecticut
School of Medicine
Department of Psychiatry
Child & Adolescent Psychiatry Division

PERMISSION TO CONTACT REFERENCES
TO BE COMPLETED BY APPLICANT

Dear Training Director:

I give permission to the Child & Adolescent Psychiatry Residency program at the University of Connecticut Health Center, School of Medicine to contact my Training Director as well as the other individuals who have provided letters of recommendation at my request.

_____ _____
Applicant's name (printed) Date

_____ _____
Applicant's Signature Date

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_____ _____
Training Director (reference # 1) Phone number

_____ _____
Reference # 2 Phone number

_____ _____
Reference # 3 Phone number
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University of Connecticut
School of Medicine
Department of Psychiatry
Child & Adolescent Psychiatry Division

Please submit the following documentation with your application:

1. Application
2. Curriculum Vitae

   Please cover all months since graduating from medical school. Explain any time gaps in your training or work in a separate letter.

3. Letters of Reference (3 required)

   One letter must be from your current Training Director. The two additional letters must be from faculty you have worked with

4. Personal Statement
5. Proof of USMLE scores
6. Letter attesting to General Psychiatry Board Eligibility
7. Verification of prior residency form
8. Proof of ECFMG
9. Proof of Citizenship
10. Permission to Contact References form

    Please date and sign the letter giving our program permission to contact your references.

11. Medical School Transcript
12. Medical School Dean's Letter