GENERAL PSYCHIATRY BOARD ELIGIBILITY ATTESTATION FORM
To be Completed by Training Director

BACKGROUND INFORMATION
Resident Applicant ________________________________________________________________

Training Director ________________________________________________________________

General Psychiatry Training Program ______________________________________________

ACGME or Equivalent Accreditation of Program _____ Yes _____ No

This is to verify that Dr. ______________________________ entered our program as a PGY____ on ___________ (mo/day/yr).

This resident is scheduled to complete the PGY____ on ___________ (mo/day/yr).

By the indicated completion date, it is expected that the resident will have satisfactorily completed ____ months of residency training.

DETAILS OF TRAINING expected to be completed as of the completion date:

____ months of primary care (IM, Peds, Fam Pract; ≥ 4 months)

____ months of neurology (≥ 2 months; one month of Pediatric Neurology may be used toward this requirement)

____ months of adult inpatient general psychiatry (6-16 months; please DO NOT include Geriatric or Addictions inpatient experiences here)

____ months of addiction psychiatry (≥ 1 month)

____ months of C/L psychiatry (≥ 2 months; one month of Pediatric C/L may be used toward this requirement)

____ months of ER/CIS psychiatry (≥ 1 month)

____ months of geriatric psychiatry (≥ 1 month)

____ months of continuous adult outpatient psychiatry (≥ 12 months)

____ months of child and adolescent psychiatry

____ SUM of MONTHS OF TRAINING CREDIT (this number should be the same as the number of months you entered above)

She/he has/will have had experience in: _____ community psychiatry

_____ forensic psychiatry
1. By the completion date, this resident will still need the following experiences to satisfy General Psychiatry Board Eligibility Requirements:

_______________________________________________________________________
_______________________________________________________________________

2. This resident is in good standing at our institution. Yes or No**

3. Disciplinary actions or remediation efforts are currently pending. Yes** or No

4. This resident left our program on_____________ (mo/day/yr).
   Reason: ______________________________________________________________

5. He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:
   1. Date____________ 2. Date____________ 3. Date _______________

CORE COMPETENCIES
Satisfactory performance has been achieved at all levels of training in the Core Competencies:

Patient Care     _____ Yes     _____ No**
Medical Knowledge _____ Yes     _____ No**
Interpersonal Skills and Communication _____ Yes     _____ No**
Professionalism  _____ Yes     _____ No**
Systems Based Practice  _____ Yes     _____ No**
Practice Based Learning & Improvement _____ Yes     _____ No**

Signature of Training Director:____________________________________    Date:___________

**Please explain any ** responses below. Thank you.