PERMISSION TO CONTACT REFERENCES
To be Completed by Applicant

Dear Training Director:

I give permission to The Institute of Living/Hartford Hospital Child & Adolescent Psychiatry Residency Training Program to contact my Training Director as well as the other individuals who have provided letters of recommendation at my request.

_____ _____
Applicant's Signature DATE

_____ _____
Printed Name DATE

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_____Phone: _____
Training Director (Reference #1)

_____Phone: _____
Reference #2

_____Phone: _____
Reference #3