

Harvard Medical School
Department of Psychiatry

Training Programs in Child and Adolescent
Psychiatry Residency Application

Cambridge Health Alliance
Children's Hospital Boston
Massachusetts General Hospital/McLean Hospital

Please submit completed applications by October 1, 2010. Interviews will be scheduled upon receipt of completed applications.

**HARVARD MEDICAL SCHOOL
DEPARTMENT OF PSYCHIATRY**

Training Programs in Child and Adolescent Psychiatry
Residency Application

Please **PRINT** or **TYPE** your responses.

Date of Application: _____

Please indicate position for which you are applying:

PGY-IV _____ PGY-V _____ PGY-VI _____

Beginning Year: _____

Please indicate the Harvard program(s) to which you are applying:

- _____ Cambridge Hospital
_____ Children's Hospital Medical Center
_____ MGH/McLean Program

Recent
Photograph
(optional)

1. PERSONAL

NAME in full _____
Last First Middle Née

DATE OF BIRTH* _____ SEX* _____ Ethnic Code* _____ OTHER PROF. NAME _____
(see below)

CURRENT ADDRESS: (preferred ___) PERMANENT ADDRESS: (preferred ___)

HOME TELEPHONE _____ WORK TELEPHONE _____

ADDITIONAL TELEPHONE NUMBERS _____ E-MAIL ADDRESS _____

SOCIAL SECURITY NUMBER _____

COUNTRY OF BIRTH: _____ COUNTRY OF CITIZENSHIP _____

Married _____ Single _____ Partnered/Not married _____

Name of spouse/partner _____

Names and ages of children:

NRMP Participant Y _____ N _____ NRMP CODE _____

* ETHNIC CODE:

ECFMG Certificate Y _____ N _____ Certificate Number** _____

1. Black
2. Asian or Pacific Islander
3. Am. Indian or Alaskan Native
4. Latino
5. White
6. Other (please specify)

* This information is for Affirmative Action reporting only.

**International medical graduates please complete additional IMG form on page 7.

2. EDUCATION

HIGH SCHOOL: From: To:

Address:

City/State/Country:

COLLEGE: From: To: Degree/Major:

Address:

City/State/Country:

GRADUATE SCHOOL: From: To: Area of Study/Degree:

Address:

City/State/Country:

MEDICAL SCHOOL: From: To:

Address:

City/State/Country:

INTERNSHIP SITE(S): TYPE:

Address:

Dates of Training:

Supervisor:

RESIDENCY SITE(S): TYPE:

Address:

Dates of Training:

Supervisor:

OTHER PROFESSIONAL TRAINING:

MENTAL HEALTH EXPERIENCE:

RESEARCH EXPERIENCE AND/OR INTERESTS:

PUBLICATIONS: YES____ NO _____ List on a separate sheet of paper if necessary.

HONORS/AWARDS:

PROFESSIONAL MEMBERSHIPS:

OUTSIDE INTERESTS/ACHIEVEMENTS:

3. EXAMINATIONS

USMLE**: Step I: Date _____ Score _____ Step II: Date _____ Score _____ Step III: Date _____ Score _____ (Please send original copy of USMLE scores)

SPECIALTY BOARDS: Specialty: _____ Date Eligible: _____
Date certified: _____ Certificate No. _____

OTHER: _____

4. LICENSURE (Past and Current)

Massachusetts (Medical):

Full license No.: _____ Dates: _____ to _____
Limited license No.: _____ Dates: _____ to _____

Other States (Medical):

State: _____ No.: _____ Dates: _____ to _____
State: _____ No.: _____ Dates: _____ to _____

Other: (Dental, psychology, social work, etc.):

State: _____ No.: _____ Dates: _____ to _____
State: _____ No.: _____ Dates: _____ to _____

Drug Enforcement Agency (D.E.A.): _____ No.: _____ Expiration Date: _____

Massachusetts Narcotics Registration _____ No.: _____ Date Issued: _____

5. EXPERIENCE

List below all health care facilities where you have provided patient care since receipt of your first professional degree. (Attach separate sheet of paper if necessary.)

Institution: _____ Dates: _____ to _____

Address: _____ Privileges and Activities: _____

Supervisor: _____

Institution: _____ Dates: _____ to _____

Address: _____ Privileges and Activities: _____

Supervisor: _____

Institution: _____ Dates: _____ to _____

Address: _____ Privileges and Activities: _____

Supervisor: _____

If no longer associated with health care facility, explain why you left.

****International Medical Graduates please complete additional IMG form on page 7.**

6. MALPRACTICE/DISCIPLINARY ACTIONS

Is there any current or pending malpractice, disciplinary, or legal action against you?
No _____ Yes _____, please explain on a separate sheet.

A. Malpractice

List and describe all settlements, malpractice claims, and lawsuits pending or closed during the previous 10 years. (Continue on separate sheet of paper, if necessary.)

Date of claim _____ Reason _____ Settlement Amount/Malpractice carrier _____

B. Miscellaneous

- a. Has your professional license in any state ever been revoked, suspended, canceled or otherwise restricted? YES _____ NO _____
- b. Have you ever been denied a professional license in any state? YES _____ NO _____
- c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? YES _____ NO _____
- d. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? YES _____ NO _____
- e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason? YES _____ NO _____
- f. Has a mental or physical impairment lasting more than one month ever interfered with your education or professional duties within the last 10 years? YES _____ NO _____
- g. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? YES _____ NO _____
- h. Have you ever been convicted in a criminal action? (Do not include a first conviction for drunkenness, simple assault, speeding, minor traffic violations, affray or disturbance of the peace, or any conviction of a misdemeanor more than five years prior to this application.) YES _____ NO _____

IMPORTANT: If you have answered "Yes" to any of the above questions, please attach a written explanation.

C. Massachusetts Board of Registration in Medicine Instructions for Health Care Facility Disciplinary Action Reports 243 CMR 3.02: Definition of "Disciplinary Action" (effective March 2, 1987)

An action which simultaneously meets the descriptions in subsections (1), (2), and (3) below, and which is limited as describe in subsections (4) and (5) below:

- (1) An action of any entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, state, or local).
- (2) An action which is:
 - (a) formal or informal, or
 - (b) oral or written
- (3) Any of the following actions or their substantial equivalents, whether voluntary or involuntary:
 - (a) Revocation of a right or privilege.
 - (b) Suspension of a right or privilege.
 - (c) Censure.
 - (d) Written reprimand or admonition.
 - (e) Restriction of a right or privilege.
 - (f) Fine.
 - (g) Required performance of public service.
 - (h) A course of education, training, counseling, or monitoring, only if such course arose out of the filing of a complaint or the filing of any other formal charges reflection upon the licensee's competence to practice medicine.
 - (i) Denial of a right or privilege.
 - (j) Resignation.
 - (k) Leave of absence.
 - (l) Withdrawal of an application.
 - (m) Termination or non-renewal of a contract with a licensee.

- (4) Divisions (i) through (m) above are "disciplinary actions" only if they relate directly, or indirectly to:
- (a) the licensee's competence to practice medicine
 - (b) a complaint or allegation regarding any violation of law or regulation (including, but not limited to, the regulations of the Board) or bylaws of a health care facility, medical staff, group practice, or professional medical association, whether or not the complaint or allegation specifically cites violation of a specific law, regulation, or bylaw.
- (5) If based upon a failure to complete medical records in a timely fashion or failure to perform minor administrative functions, first or second written reprimand or admonition, or a first or second suspension or restriction of a right or privilege (if less than ten working days in any twelve-month period), is not a "disciplinary action" for the purposes of mandatory reporting to the Board.

INTERNATIONAL MEDICAL GRADUATE
(Supplementary Form)

Name: _____

Medical School: _____ Graduation Date: _____

Country of Birth: _____ Country of Citizenship: _____

U.S. Immigration Status: _____
Naturalized _____ Permanent resident _____ Visa: _____ JI _____ HI _____ Other _____
Issue date _____ Expiration Date _____ Number _____

No current status, must apply for _____ status for period of residency.

If applying for a J I or HI Visa, please answer the following:

Married _____ Single _____ Partnered/not married _____

Name of Spouse/Partner: _____

Names and Ages of Children: _____

Social Security Number: _____

Did you participate in a Fifth Pathway Program: _____ If yes, describe _____

Was there a contractual agreement between your medical school and the sponsor of the clinical rotation?

Yes _____ No _____ Describe: _____

ECFMG Certificate valid through: _____

Examinations:

English language exam: Name: _____ Date: _____ Pass: _____ Fail: _____

Other qualifying/licensing exams:

Name: _____ Date taken/scheduled Score

Location: _____ Part I _____

_____ Part 2 _____

_____ Part 3 _____

Name: _____ Date taken/scheduled Score

Location: _____ Part I _____

_____ Part 2 _____

_____ Part 3 _____

Clinical Experience in USA:

I certify that, to the best of my knowledge and belief, all of the information provided in this application is true, correct, and complete.

Signature of Applicant: _____ Date: _____

In addition to the documents requested in the main application, please have your medical school send an original transcript and have ECFMG send your ECFMG certificate. We also require a letter from any previous training directors; a letter from a recent medical supervisor; and a brief statement of the reason you are interested in child and adolescent psychiatry including your career goals in the field.

ADDITIONAL INFORMATION:

1. Please have your Dean's Letter and original transcript sent to each of the programs to which you are applying.
2. References: You are responsible for having all the following letters sent to us; but we would like you to provide the names of individuals from whom you are requesting letters.

a. Medical School Dean's Letter

Name: _____
Hospital: _____

b. Director of Medical Internship

Name: _____
Hospital: _____

c. Director of General Psychiatry Residency Training Program

Name: _____
Hospital: _____

d. Director of other post-graduate medical training program(s).

Name(s): _____
Hospital(s): _____

e. One letter from Supervisor in General Psychiatry Training Program familiar with your work with and/or knowledge of children, adolescents, families and development.

Name: _____
Hospital: _____

f. One letter from supervisor of your choice in General Psychiatry Training Program.

Name: _____
Hospital: _____

3. Please attach a curriculum vitae and a brief one page personal statement including aspects of your background, experiences, and interests.

4. It is the applicants responsibility to have his/her current psychiatry training director complete the letter (page 9) attesting to General Psychiatry Board eligibility.

5. Applications should be sent to the training directors of each of the Harvard programs to which you are applying.

Cambridge Hospital
Program
1493 Cambridge Street
Cambridge, MA 02139
ATT: Cynthia Telingator, M.D.
617-665-1587
ctelingator@challiance.org

Children's Hospital Boston
300 Longwood Avenue, HU-121
Boston, MA 02115
ATT: Enrico Mezzacappa, M.D.
617- 355-7605
Enrico.mezzacappa@childrens.harvard.edu

MGH/McLean Psychiatry
WACC 812
15 Parkman Street
Boston, MA 02114
ATT: Eugene V. Beresin, M.D.
617- 726-1620
eberesin@partners.org

I certify that all information in this application is true to the best of my knowledge.

I agree to abide by the Bylaws, rules, regulations and policies of the Professional Staff and of the Hospital.

I agree to undergo a mental or physical examination pursuant to Section 3.02 of the Bylaws of Massachusetts Board of Registration in Medicine (see page 5), if requested and, if this shows evidence of mental or physical impairment, to provide evidence that the impairment does not interfere with my professional competence.

I authorize members of any hospital, other health care facility or professional origination, or any physician or other person with which I have had employment, practice, association or privileges, to release to the General Director or the Chief of the Service or Department of the Hospital to which I am applying for appointment, or their designees, information regarding my professional skills, any pending or final disciplinary actions or malpractice actions, and any other information relevant to be my character or professional competence, provide such information is given' for the purposes of credentialing and in good faith and without malice.

I authorize the General Director or the Chief of the Service or Department of the Hospital in which I have or have had privileges, or their designees, to exchange information with those individuals or offices involved in the credentialing of any other health care facility and any professional organization with which I have had any employment, practice association or privileges, regarding an assessment of my professional skills, any pending or final disciplinary action or malpractice actions, and any other information relevant to in character or my professional competence, provided such information is given for purposes of credentialing and in good faith and without malice.

I authorize my malpractice carrier(s) to release to the General Director or the Chief of the Service or Department of the Hospital to which I am applying for appointment, or their designees, the following information concerning all malpractice claims or actions for damages pending or closed during the previous ten years: policy number; name, address, and age of claimant or plaintiff, nature and substance of claim; date and place a which claim arose; amount paid, if any; and the dates and manner of disposition, judgment, settlement or otherwise; and the date and reason for final disposition, if no judgment, or settlement, provided such information is given for purposes of credentialing and in good faith and without malice.

I release from civil liability the General Director and the Chief of the Service or Department of the Hospital to which I am applying for appointment, or their designees, the applicable service specific quality assurance committee, any other hospital or other health care organization and any other medical professional organization, and any other person authorized by me, who furnishes or reviews information, or who makes recommendations in connection with this application for appointment, provided such information, review or recommendations are given or performed in good faith and without malice.

Date: _____ Signature of Applicant: _____

Print Name of Applicant: _____

**Letter Attesting to General Psychiatry Board Eligibility
To be completed by Training Director**

TO: Child and Adolescent Psychiatry Training Director:
Eugene Beresin, M.D.
Enrico Mezzacappa, M.D.
Cynthia Telingator, M.D.

FROM: General Psychiatry Training Director

RE: Applicant: _____

This is to verify that Dr. _____ entered our program as a PGY _____ on _____ (mo/da/yr).
By the date of entry into child and adolescent psychiatry training, he/she will have satisfactorily completed the following:

- _____ months of primary care: internal medicine, pediatrics, family practice. (Four months minimum)
- _____ months of neurology (Two months minimum - One month may be in child neurology.)
- _____ months of adult inpatient psychiatry (Six months minimum, 16 months maximum)
- _____ months of continuous adult outpatient psychiatry (12 FTE months minimum)
- _____ months of child and adolescent psychiatry (Two months minimum – Not required if residents is completing training in child and adolescent psychiatry.)
- _____ months of consultation/liaison psychiatry (Two months minimum – One month may be in child consultation/liaison psychiatry.)
- _____ months of geriatric psychiatry * (One month minimum for residents entering PGY 1 training after January 1, 2001.)
- _____ months of addiction psychiatry* (One month minimum for residents entering PGY 1 training after January 1, 2001.)

** Can be double-counted from inpatient or outpatient with adequate documentation.
For residents entering residency training prior to January 1, 2001, experience in geriatric and addiction psychiatry may be substituted for one month of geriatric psychiatry and one month of addiction psychiatry.*

- He/she has also had experience in:
- ___ Emergency psychiatry (must be completed during general psychiatry residency.)
 - ___ Forensic psychiatry (Experience may be completed in child and adolescent residency.)
 - ___ Community psychiatry (Experience may be completed in child and adolescent residency.)

He/she will have completed 36 months of training. YES/NO (Please circle one)

Dr. _____ must complete the following psychiatry training to satisfy adult program requirements.

Clinical Skills Verification (CSV) Exams #1 passed on (date)_____, #2 passed on (date)_____,
and #3 passed on (date)_____.

Signature of General Psychiatry Training Director: _____ Date: _____

This form must be completed and returned to Drs. Beresin, Mezzacappa and/or Telingator or applicant will not be ranked on Match list.