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

Child Psychiatry Fellowship Application Form

Full Name ______________________________ Date ________________

Social Security Number ______________________________ Post Grad Year ____________

Present Address ____

Present Telephone Numbers (home) ______________ (work) ____________________

E-mail address ____

Date of Birth ______________ Place of Birth ______________________________

Citizenship ______________ Visa Status (if foreign national) ____________________

Passed USMLE step 1 ____________ (Date) USMLE Step II ____________ (Date) USMLE Step III ____________ (Date)

Passed ECFMG Exam? ______________ (Date) ECFMG number ______________________

Licensed to practice medicine? __________ Where? ______________________

Board Certified? If "yes" enter name of Board and Year Certificate ______________________

Graduate Education

Start with most recent education beyond college, include internship and residencies.
For foreign degrees give U.S. equivalent in proper column

Name of Institution, School and/or Department and Location	Major Field Of Study	Month & Year	Degree, if any	Equivalent U.S. Degree

Undergraduate Education

(start with most recent education)

Name of Institution, School and/or Department and Location	Major Field Of Study	Month & Year	Degree, if any	Equivalent U.S. Degree

Relevant Work Experience

(include major positions held starting with most recent)

Name and Location of Employer	Position Title	From (Date)	To (Date)

Publications (Use additional sheet if necessary):

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Names and contact information of three persons asked to write letters of recommendation:

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____

Narrative:

1. Why do you want to pursue child psychiatry?

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2. What past experiences have influenced this decision?

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Return To: Daniel F. Connor, MD
Division Chief of Child and Adolescent Psychiatry &
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: connor@psychiatry.uchc.edu

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

From: Training Director, ____
General Psychiatry Training Program

RE: Applicant: ____

This is to verify that Dr. ________________________ entered our program as a PGY- _____ on ____________ (mo/day/yr). She/he will have satisfactorily completed the following training:

Please enter the number of months completed by date of entering child and adolescent psychiatry training.

_____ months of primary care (internal medicine, pediatrics, or family practice; 4 months minimum)

_____ months of neurology (2 months minimum with at least one month with adults)

_____ months of adult inpatient psychiatry (9 months adult inpatient minimum)

_____ months of continuous adult outpatient psychiatry (12 FTE months minimums)

_____ months of consultation liaison (2 months minimum with at least one month with adults)

She/he has/will have had experience in (please check):

_____ geriatric psychiatry

_____ community psychiatry

_____ forensic psychiatry

_____ emergency psychiatry

_____ addiction psychiatry

Dr. ________________________ left our program on __________________ (mo/day/yr).

Dr. ________________________ must complete the following psychiatry training to satisfy adult program requirements: ____

____

Signature of General Psychiatry Training Director: ______________________________ Date: _________

Please return this form along with three letters of recommendation to:

Daniel F. Connor, MD
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Training Director of Child and Adolescent Psychiatry
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