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 see individual program information for application deadline. Interviews will be scheduled upon receipt of completed applications.
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 Health Alliance
____  Children’s Hospital Medical Center
____  MGH/McLean Program

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: __________________________

Significant other: ____________________________________________________________

Names and ages of children:

________________________________________________________________________

________________________________________________________________________

NRMP Participant  Y____N_____NRMP CODE __________________________  * ETHNIC CODE:

ECFMG Certificate  Y____N_____Certificate Number** ________________  1. Black

* This information is for Affirmative Action reporting only.
**International medical graduates please complete additional IMG form on page 7.
## 2. EDUCATION (please only list items not on your CV)

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<th>EDUCATION Level</th>
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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.
(1) 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.
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: _____________________________

ECFMG Certificate valid through: ___________________________

Examinations:
English language exam: Name: __________________ Date: ___________ Pass:______ Fail:____

Other qualifying/licensing exams:

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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 Harvard program to which you are applying. All application materials to the MGH/McLean Child and Adolescent Psychiatry Residency Program Manager, Elaine Almeida.

Cambridge Hospital Psychiatry Program
1493 Cambridge Street
Cambridge, MA 02139
ATT: Cynthia Telingator, M.D.
617-665-1587
telingator@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
WACC 812
15 Parkman Street
Boston, MA 02114
ATT: Elaine Almeida
617- 726-1620
ealmeida@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)

_____ months of addiction psychiatry* (One month minimum)

_____ months of elective

* 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:

_____ Months of emergency psychiatry (must be completed during general psychiatry residency.)

_____ Months of forensic psychiatry (Experience may be completed in child and adolescent residency.)

_____ Months of 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 Evaluation
Number one 
Number two
Number three

Date completed: ____________________________

ABPN-Certified examiner: ____________________________
This form must be completed and returned to Drs. Beresin, Mezzacappa and/or Telingator or applicant will not be ranked on Match list.