BRODY SCHOOL OF MEDICINE AT EAST CAROLINA UNIVERSITY
DEPARTMENT OF PSYCHIATRIC MEDICINE
DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY

Attach a Recent 2 X 2 Photo

Please Print Name and Sign on the back of the photo

Application for Two Year Fellowship in Child and Adolescent Psychiatry Residency

Date of Application:_____________ **Application for the Entering Year:** ___________ **Position Desired:** 1st yr. ___ 2nd year___

Name: (First, Middle, Last)) ____(Maiden)___________________

Mailing Address: ____
(Street, City, State, Zip)

Permanent Address: ____
(Street, City, State, Zip)

Current Home Telephone: ______________ **Work/Daytime Telephone**: __________________ **Cell Phone**: ___________________

Pager Number: _________________________________ **E-mail Address:** ____

Age: ______ **Date of Birth:** ________________ **Sex:** ___**Male** ___**Female** **Birthplace:** ___________________________

Military Status or Previous Experience:____

Eligibility Requirements:
Note: H Visas are not accepted. Applicants must comply with one of the following:

I am (check one of the following):

______ A citizen or national of the United States
______ Have a J-1 Visa
______ Pending Permanent Resident
With valid Employment Authorization Card
______ Refugee with valid Employment Authorization Card
______ Permanent Resident – Alien # A_______________
______ Applying for a J-1 Visa
______ Political Asylum
with valid Employment Authorization Card

ECFMG Certification Number:________________ **Date Issued:** ___________________

Under graduate Experience Name and Location	Dates Attended	Degree
	From: _________ To: _________	
	From: ________ To: _________	
	From: ________ To: _________	

Medical/Graduate School Experience Name and Location (City/State/Country(	Dates Attended	Degree
	From: _________ To: _________	
	From: ________ To: _________	
	From: ________ To: _________	

Post-Graduate/Hospital Experience Program Name and Location	**Dates Attended**	**Type of Service**
	From: ________ To: ________	
	From: ________ To: ________	
	From: ________ To: ________	

USMLE :
Residents must have passed USMLE Step 3 or COMLEX Level 3 examination as a condition for acceptance into the program.

(Three digit Score)
USMLE Step 1 # Attempts ___ Year/Score ________________________ Passed Date/Score____________________ ______
USMLE Step 2 CK # Attempts ___ Year/Score ________________________ Passed Date/Score____________________ ______
USMLE Step 2 CS # Attempts ___ Year/Score________________________ Passed Date/Score____________________ ______
(Pass/Fail)
USMLE Step 3 # Attempts ___ Year/Score________________________Passed Date/Score____________________ ______

***If you took the COMLEX please fill in the above USMLE blanks and check this box ☐**

PRITE Scores	**Global Psychiatry Standard Score**	**Percentage**	**Global Neurology Standard Score**	**Percentage**
PGY1	______________	___________	_____________	__________
PGY2	______________	___________	_____________	__________
PGY3	______________	___________	_____________	__________
PGY4	______________	___________	_____________	__________

Passed three (3) Clinical Skills Exams supervised by a Board Certified Psychiatrist: Dates __________ __________ __________

Unrestricted Medical License In: Year _________ State_______________________________________ Number _____________

Please attach an updated resume or CV.

Please attach your Personal Statement.

List of documents to be sent.

- **Evidence of US citizenship, permanent residency or J1 Visa**
- **Copy of MD/DO diploma**
- **Copy of USMLE scores**
- **Copy of PRITE Scores**
- **Copy of ECFMG Certificate**
- **Certification of General Psychiatry Training**
- **Medical school transcript – sent directly from Medical School**

Supporting Documents:

Please have three or more letters of recommendation from persons with whom you have worked and/or studied, in the institutions you have named above, sent directly to the address below.

Name Address:

1. ____

2.____

3.____

Please have your training director submit a formal letter, as well at the attached Certification of General Training. (Formal Letter requirements attached)

Applicant's affidavit:
I certify that the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my acceptance. I hereby authorize my present/past employers to furnish Brody School of Medicine with their records of service if requested. I agree if accepted into the program to supply Brody School of Medicine/Pitt County Memorial Hospital with such verification as they may be permitted by Federal, State, and Municipal codes and regulations to request of me, and to abide by all Brody School of Medicine/Pitt County Memorial Hospital's rules and regulations.

Date:__________________ Signature:____

Submit Application and all documentation to:

Kaye L. McGinty, M.D.
Training Director
Child and Adolescent Psychiatry Residency
Brody School of Medicine at East Carolina University
600 Moye Boulevard, Suite 4E94
Greenville, North Carolina 27834

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