**Certification of General Psychiatry Training**

Date_____ Program ID#_____

This is to verify that Dr. _____ entered the psychiatry program as a PGY _____ on _____ (month/day/year).

He/she will have satisfactorily completed the following training in our program:

_____ months of primary care

_____ months of neurology

_____ months of adult impatient psychiatry

_____ months of adult outpatient psychiatry

_____ months of child and adolescent psychiatry

_____ months of consultation liaison psychiatry

He/she has had experience in:

_____ geriatric psychiatry

_____ community psychiatry

_____ forensic psychiatry

_____ emergency psychiatry

_____ addiction psychiatry

Psychiatry Clinical Skills Verification

| | Dates taken: | Date Passed | Physician |
|---|---|---|---|
| Exam 1 _____ | _____ | _____ | _____ |
| Exam 2 _____ | _____ | _____ | _____ |
| Exam 3 _____ | _____ | _____ | _____ |

Dr. _____ will complete his/her training on _____ (month/day/year)

Sincerely,

_____ (Program Director)