Geriatric Psychiatry Fellowship
Training Verification Form

To: VTCSOM Geriatric Psychiatry Fellowship Program Director (Azziza Bankole, MD)

From: Residency Program Director (Name) _____

Residency (Institution): _____

Re: Applicant: _____

Dear Sir or Madam: The above physician has applied for entrance into the Geriatric Psychiatry Fellowship at the Virginia Tech Carilion School of Medicine. We would appreciate it if you could verify the following information.

Dr. _____ entered our program as a PGY_____on _____(date).

By _____(date) this physician **will have satisfactorily completed** the following training:

- _____ FTE months of primary care: internal medicine, pediatrics, family practice (four months minimum)
- _____ FTE months of neurology (two months minimum; one-month may be child neurology)
- _____ FTE months of adult inpatient psychiatry (6 FTE months)
- _____ FTE months of adult outpatient psychiatry (12 FTE months, of which a minimum of 20% must be a continuous experience)
- _____ FTE months of Child and adolescent psychiatry (not required if the resident will be completing training in child and adolescent psychiatry)
- _____ FTE months of months of consultation/liaison psychiatry (two months minimum; one-month may be child C-L)
- _____ FTE months of geriatric psychiatry (one-month minimum, either in or outpatient)
- _____ FTE months of addiction psychiatry (one-month minimum, either in or outpatient)
- _____ Psychotherapy competencies

The applicant has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations: 1. Date:_____ 2. Date:_____3. Date: _____

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He or she has had or will have had experience by the described date in:

Community psychiatry: Yes ☐ No ☐ (date) _____

Forensic psychiatry: Yes ☐ No ☐ (date) _____

Emergency psychiatry: Yes ☐ No ☐ (date) _____

ECT: Yes ☐ No ☐ (date) _____

The following general psychiatry requirements will not be completed by (date) _____ :

Signature of Program Director: _____ Date: _____

Printed name of Program Director: _____