UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE
Psychiatry Residency Program Summary Statement of Training

This is to certify that _____ has completed the following training in the ACGME accredited Psychiatry Residency Training Program at the University of Washington and Affiliated Hospitals.

Start Date: _____ Date of Completion: _____
Training was completed: full-time from _____ to _____
_____% time from _____ to _____

CLINICAL EXPERIENCES

1. Internship Year Start Date: _____ End Date: _____

_____ At the University of Washington
___ 4 mos Medicine ___ 4 mos Pediatrics ___ 2 mos Medicine, 2 mos Pediatrics
___ 2 mos Adult Neurology ___ 1 mo Adult and 1 mo Pediatric Neurology
___ 6 mos Inpatient Psychiatry
_____ Elsewhere
___ At least 4 months primary care experience at _____
Including ___ 0 ___ 1 ___ 2 months of Neurology

2. PGY 2-4 Clinical Experience

_____ mos Adult Inpatient Psychiatry (to make a total of ___ mos adult inpatient psychiatry)
_____ mos Consultation-Liaison Psychiatry
_____ mos Emergency Psychiatry
_____ mos Child and Adolescent Psychiatry
_____ mos Addiction Psychiatry
_____ mos Geriatric Psychiatry
_____ mos Adult Outpatient Psychiatry (including at least 20% long-term care for 12 mos and ___ mos ongoing 10% long-term care clinic)
_____ mos Elective rotations
Experience in: ___ Forensic Psychiatry ___ Community Psychiatry ___ ECT

On _____, the Resident Education Steering Committee reviewed this resident's overall performance and concluded:

_____ This resident's performance has been entirely satisfactory. There is NO evidence of unethical or unprofessional behavior. There are NO questions as to this resident's clinical competence. There is NO evidence of substance abuse or of emotional or physical problems that could impair this resident's capacity to practice psychiatry.
_____ This resident has been placed on probation. Please see reverse for summary.
_____ The Committee noted other relevant issues. Please see reverse side for description.
_____ This resident is now judged to be capable of practicing psychiatry competently and independently in the community.

Date: _____ Signed: _____
Suzanne Murray, M.D.
Associate Professor and Director, Psychiatry Residency Program

PROBATION

Summary of Events:

Resident's Comments:

Date: _____ **Signed: _____**

ADDITIONAL PERFORMANCE INFORMATION

Summary of Events:

Resident's Comments:

Date: _____ **Signed: _____**