

**SAMPLE CHILD NEUROLOGY LETTER**

<on letterhead>

<date>

Program ID: \_\_\_\_\_

Larry R. Faulkner, M.D.  
Executive Vice President  
American Board of Psychiatry and Neurology  
2150 E. Lake Cook Road, Suite 900  
Buffalo Grove, IL 60089

Re: <Name of resident>

Dear Dr. Faulkner:

This is to verify that Dr. <Name> entered our child neurology residency program as a PGY-<year> on <month/day/year>. S/he <has/will satisfactorily> complete(d) the following training:

\_\_\_\_\_ Clinical child neurology (12 months minimum)

\_\_\_\_\_ Clinical adult neurology (12 months minimum)

\_\_\_\_\_ Outpatient clinical child neurology (4 months minimum included in 12 months above. Must also include a longitudinal/continuity clinic ½ day weekly throughout the program)

\_\_\_\_\_ Management of children and adolescents with psychiatric disorders under the supervision of a qualified child and adolescent psychiatrist (1 month minimum)

\_\_\_\_\_ Training in the basic and related sciences (2 months minimum)

\_\_\_\_\_ Electives (3 months minimum)

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Clinical Skills Evaluations

Evaluator Names (3 req'd)

Date Completed:

<input type="checkbox"/>	Adult Neurology	_____	_____
<input type="checkbox"/>	Critical Care	_____	_____
<input type="checkbox"/>	Neuromuscular	_____	_____
<input type="checkbox"/>	Episodic (headache, seizure)	_____	_____
<input type="checkbox"/>	Neurodegenerative (movement/inflammatory)	_____	_____

Dr. <Name> has demonstrated sufficient professional ability to practice competently and independently. There is no evidence of unethical behavior, unprofessional behavior, or clinical incompetence.

Dr. <Name> <left/successfully completed/will complete> the program on <month/day/year>.

Sincerely,

<Name, MD>  
Child Neurology Residency Director