

## CAP checklist & sign off

To be submitted by trainees and Fellows completing the Certificate of Advanced Training in Child and Adolescent Psychiatry.

Please submit this form to the College's training team. **Email:** [training@ranzcp.org](mailto:training@ranzcp.org); **fax:** +61 3 9642 5652; **post:** RANZCP, Training, 309 La Trobe Street, Melbourne VIC 3000, Australia.

**Please fill in the completion dates of the training requirements below and attach final qualitative report.**

Trainee name

RANZCP ID

### FORMAL CHILD AND ADOLESCENT PSYCHIATRY TEACHING COURSE

Program name

Course completion date

DOAT signature

Date

Satisfactorily completed Certificate of Advanced Training in Child and Adolescent psychiatry training requirements			Completion date
24 months FTE training in accredited child and adolescent training post, including:			
• 6 months FTE community setting	DOAT initial		
• 6 months inpatient setting	DOAT initial		
Written learning and development plan for each training year, agreed with and submitted to the DOAT.	Year 1	DOAT initial	
	Year 2	DOAT initial	
Eight Stage 3 child and adolescent psychiatry EPAs	Year 1	ST3-CAP-AOP-EPA1	
		ST3-CAP-AOP-EPA2	
		ST3-CAP-AOP-EPA3	
		ST3-CAP-AOP-EPA4	
	Year 2	ST3-CAP-AOP-EPA5	
		ST3-CAP-AOP-EPA6	
		ST3-CAP-AOP-EPA7	
		ST3-CAP-AOP-EPA8	
Elective EPA (non-mandatory)		ST3-CAP-AOP-EPA9	

Satisfactorily completed Certificate of Advanced Training in Child and Adolescent psychiatry training requirements							Completion date
Minimum one OCA per each 6-month FTE rotation with a child, adolescent or family	Year 1	OCA in rotation 1					
		OCA in rotation 2					
	Year 2	OCA in rotation 3					
		OCA in rotation 4					
Psychotherapy for 9 patients		<i>please select a modality and an age range for each patient</i>					
		3 structured or manualised	3 dynamic	3 dyadic or family / group in any model	3 patients under 6 years old	3 patients 6–12 years old	
Patient 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient 9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Formative & summative forms	Rotation 1	Mid-rotation ITA form					
		End-of-rotation ITA form					
	Rotation 2	Mid-rotation ITA form					
		End-of-rotation ITA form					
	Rotation 3	Mid-rotation ITA form					
		End-of-rotation ITA form					
	Rotation 4	Mid-rotation ITA form					
		End-of-rotation ITA form					
	<i>For part-time trainees:</i> Additional Rotations may be required	Mid-rotation ITA form					
		End-of-rotation ITA form					
		Mid-rotation ITA form					
		End-of-rotation ITA form					

**TRAINEE DECLARATION**

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I confirm that I have completed 24 months FTE of child and adolescent psychiatry certificate training and all the requirements as listed above.

I have attached the final qualitative report for the Chair to review.

Trainee signature		Date	
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**DIRECTOR OF ADVANCED TRAINING DECLARATION**

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Dr ..... has satisfactorily completed 24 months FTE of child and adolescent psychiatry certificate training and all the requirements as listed above. I recommend award of the Certificate of Advanced Training in Child and Adolescent Psychiatry.

DOAT name		RANZCP ID	
DOAT signature		Date	

*The College training team will audit the relevant documentation to ensure all documents have been submitted and recorded accurately. This form will then be forwarded to the Chair of the Subcommittee for Advanced Training in Child and Adolescent Psychiatry (SATCAP) alongside the final qualitative report.*

<i>Office use only</i>	
Date checklist & sign off received .....	Zone .....
<b>SATCAP CHAIR DECLARATION</b>	
I concur that Dr .....has satisfactorily completed 24 months FTE of child and adolescent psychiatry certificate training and all the requirements and is eligible to be awarded the Certificate of Advanced Training in Child and Adolescent Psychiatry.	
SATCAP Chair name .....	
SATCAP Chair signature .....	Date .....