Sacramento County
Department of Health Services
Division of Behavioral Health Services

**RESIDENT/FELLOW APPLICATION**

Agency_____ Date_____
Contact Person_____ Phone_____
Contact Person Email_____

I attest that I, _____, am a medical resident in a California Accreditation Counsil for Graduate Medical Education (ACGME) accredited postgraduate training program.

Name of University_____

Select classification:

☐ Postgraduate Training Licensee (PTL). I attest that I possess an active PTL license and may only engage in the practice of medicine in connection with my duties with this residency program under the supervision of a licensed physician.
☐ Psychiatry Resident/Fellow. I attest that I possess an active Physician and Surgeon license or Doctor of Osteopathy license and am participating in a residency/fellowship program specializing in the field of psychiatry under the supervision of a licensed psychiatrist

Select correct statement(s):

☐ I have a restricted license. I am under clinical supervision by a licensed physician and am exempt from the requirement to enroll in PAVE and Medi-Cal Rx.
☐ My license is unrestricted and I will provide direct care services to clients. (PAVE enrollment required)
☐ My License is unrestricted and I will prescribe mediations to clients. (Medi-Cal Rx enrollment required)

My residency begins on _____ and ends on _____

Resident/Fellow Signature_____ Date_____

Clinical Supervisor's Name_____ Discipline/License#_____

Clinical Supervisor's Signature_____ Date_____

QM Approval: Rolanda Adams, LCSW_____ Date_____