

**LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE
CLERKSHIP EVALUATION FORM**

STUDENT'S NAME _____

CLERKSHIP: **FAMILY MEDICINE**

HOSPITAL/SITE _____

CLERKSHIP DATES _____

OBSERVED CLINICAL PERFORMANCE GRADE (circle **one** number)

HONORS			HIGH PASS			PASS			LOW PASS		FAIL
25	24	23	22	21	20	19	18	17	16	15	14 - 0

I. CLINICAL SKILLS - Student has demonstrated his/her ability to:

1. Obtain an accurate history.
2. Perform a thorough physical exam.
3. Construct a complete problem list.
4. Formulate an appropriate differential diagnosis and initial diagnosis plan.
5. Accurately interpret laboratory and special procedures applicable to the clerkship.
6. Incorporate psychosocial factors in assessing and treating patients.
7. Incorporate cost factors in evaluating and treating patients.
8. Appropriately recommend use of consultants/referrals.

STA	A	SLA	D	NA	COMMENTS ON STRENGTHS AND WEAKNESSES

STA = Strongly Agree
A = Agree

D = Disagree
SLA = Slightly Agree

NA = Not Applicable

Student's Name _____

II. COMMUNICATION SKILLS: Ability to:

	STA	A	SLA	D	NA	COMMENTS ON STRENGTHS OR WEAKNESSES
1. Write a coherent history and physical.						
2. Present a history and physical clearly.						
3. Write understandable progress notes.						
4. Present the patient status, important data and ongoing plans.						
5. Effectively communicate with patients and their families.						
6. Effectively motivate and instruct patients in health promotion.						

IIIA. BASIC KNOWLEDGE: Student has/can:

	STA	A	SLA	D	NA	COMMENTS ON STRENGTHS OR WEAKNESSES
1. Acquired knowledge of specific topics related to student's patients.						
2. Use of textbooks.						
3. Use of medical literature.						
4. Overall knowledge of clerkship field.						

IIIB. PROGRESS: Please circle one of the following:

- | | | | | |
|-------------------------------------|---|--|------------------------------|-----------------------------------|
| 1 | 2 | 3 | 4 | 5 |
| Student showed no effort or no gain | Showed minimal or inconsistent effort or gain | Showed good, consistent effort or gain | Showed strong effort or gain | Made extraordinary effort or gain |

Student's Name _____

IV. PERSONAL CHARACTERISTICS

Listed below are a number of personal characteristics important to professional growth. Please consider each of them carefully and indicate your assessment with a check mark.

ACC - acceptable

NI - needs improvement

NOTE: IF ANY ATTRIBUTE IS CHECKED "NEEDS IMPROVEMENT," COMMENT MUST BE PROVIDED.

ATTRIBUTE	ACC	NI	COMMENTS ON STRENGTHS OR WEAKNESSES
Dress/grooming			
Behavior			
Motivation			
Judgment			
Reliability			
Response to criticism			
Interpersonal relationships			
Sensitivity to patient's needs			

V. COMMENTS

Evaluators must provide a written summary of the assessment of the student's major strengths and weaknesses as well as an appraisal of the student's overall performance. Comments are used to: 1) provide performance information for the student's permanent academic record which will be used in the Dean's letter and 2) provide constructive feedback to the students. In order to facilitate both needs, two categories of evaluation comments are requested.

1. COMMENTS FOR THE STUDENT'S PERMANENT RECORD are extremely important and should be clear, information, and complete. These narrative comments along with the Sections 1-IV above will comprise the official documentation of this student's performance for the academic cumulative narrative transcript which is provided to residency program directors along with the Dean's letter of recommendation.

Please write clearly or type comments on the next two pages.

COMMENTS FOR THE STUDENT'S PERMANENT RECORD

Student's Name _____

Please write clearly or type.

Signature of Site Evaluator _____

Date _____

Typed Name of Site Evaluator _____

FOR DEPARTMENT USE ONLY

Student's Name _____

2. CONSTRUCTIVE CRITICISM is intended to recommend solutions for identified problems described in the comment sections. These constructive criticisms will be shared with the student and retained in the department only.

Please write clearly or type.

Signature of Evaluator _____

Date _____

Typed Name of Evaluator _____

Please **fax** a copy of the “composite” evaluation to 708-216-1104 **or** mail the original to:
Cathryn Merrick Moore, Education Coordinator
Department of Family Medicine, Bldg. 54, Room 252
2160 S. First Avenue
Maywood, IL 60153