Medical Student Evaluation Form

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<th>Category</th>
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<td>Knowledge of Pathophysiology</td>
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<td>Data gathering &amp; interviewing</td>
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<td>Diagnostic Ability</td>
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<td>Therapeutic Ability</td>
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<td>Rapport with Staff &amp; patients</td>
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<td>Overall progress &amp; performance</td>
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Comments:

Student Name

Clinical Rotation

Begin: ____________ End: ______________

Dates of Rotation

Attending/Supervising Physician

Phone: (+211) 33 820 98 05
Fax: (+211) 33 820 98 04
Comments for Dean’s letter:

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Attending/Supervising Physician: ______________________________________________________

Sponsoring Institution: ______________________________________________________________

Address: ______________________________________________________________________________

__________________________________________________________

Student Name _______________________________________________Clinical Rotation __________

Signature of Attending/Supervising Physician ___________________________ Date ________________

Please post the original signed evaluation to:

St. Christopher IMD College of Medicine
Clinical Department
155 Westridge Parkway, Suite 306
McDonough, GA 30253
Phone (1) 678-432-2045
Fax (1) 678-432-2086
Email: clinicalsciences@stchris.edu

Please provide photocopies for both the department of medical education at the sponsoring institution and for the medical student.