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Medical Student Evaluation Form

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_____ _____
Student Name Clinical Rotation

Begin : _____ End : _____ _____
Dates of Rotation Attending/Supervising Physician

Category									**Comments**
Knowledge of Pathophysiology	65	70	75	80	85	90	95	100	_____ _____
Data gathering & interviewing	65	70	75	80	85	90	95	100	_____ _____
Physical Examination	65	70	75	80	85	90	95	100	_____ _____
Diagnostic Ability	65	70	75	80	85	90	95	100	_____ _____
Therapeutic Ability	65	70	75	80	85	90	95	100	_____ _____
Chart Work	65	70	75	80	85	90	95	100	_____ _____
Rapport with Staff & patients	65	70	75	80	85	90	95	100	_____ _____
Overall progress & performance	65	70	75	80	85	90	95	100	_____ _____

Comments for Dean's letter:

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 departement of medical education at the sponsoring institution and for the medical student.