Clinical Student Evaluation Form

Student Name: ____________________________________________________________

Hospital: ______________________________________________________________

Hospital Address: ________________________________________________________

Clinical Rotation: __________________________ | Number of weeks:_______

Dates: From __________ Through __________

Please e-mail evaluation. To expedite mail service to Curacao, send originals to:
St. Martinus Administrative Services
8705 Shoal Creek Blvd., Suite 112
Austin, TX 78757
Tel: el: +1.877.681.4SMU(4768); +1.718.841.7682
Fax: +1.718.732.2503
Email: vp@martinus.edu

Supervising Physician is to complete this form, the grade, and most importantly, the narrative. In addition, the Clinical Dean must be called directly by telephone at (512) 940 6615 to discuss this student’s performance if necessary.

Grade Key:  A = 90-100% | B = 80-89% | C = 70-79% | F = <70%

1) Relationship with faculty, staff, and fellow students:
   Comments: A - B - C - F

2) Communication ability and ethics with patients:
   Comments: A - B - C - F

3) Reliability, maturity, and ability to handle criticism:
   Comments: A - B - C - F

4) Detailed history:
   Comments: A - B - C - F
5) Physical examination:  
A - B - C - F  
Comments:

6) Written record:  
A - B - C - F  
Comments:

7) Case presentation:  
A - B - C - F  
Comments:

8) Differential diagnosis:  
A - B - C - F  
Comments:

9) Pharmacotherapy:  
A - B - C - F  
Comments:

10) Interpretation of simple lab tests:  
A - B - C - F  
Comments:

11) Ability to think, integrate, and learn independently:  
A - B - C - F  
Comments:

12) Conscientiousness, initiative, and enthusiasm:  
A - B - C - F  
Comments:

13) Depth of knowledge and ability to integrate into clinical practice:  
A - B - C - F  
Comments:
14) Overall impression (including useful suggestions of points to focus and improve upon):

Use additional paper if necessary to provide the details necessary for a formal “Dean’s Letter”:

A - B - C - F

Comments:

Signature of Physician Supervising Rotation: ______________________________________________________

Printed Name: ___________________________ Date: ___________ Phone#: ____________________________

E-mail Address: ___________________________________________