RESIDENT ATTENDING & SELF ROTATION EVALUATION

NAME: ___________________________  SERVICE: __________________________

ATTENDING(S): ________________________________________________________

Education:
1. Was the educational environment a positive experience?   Yes __   No __
   If not, why? __________________________________________________________

2. Were there scheduled lectures and were they given a majority of the time?   Yes __   No __

3. Was the educational experience additive to your current knowledge base?   Yes __   No __
   If not, why? _______________________________________________________

4. Did the educational component outweigh the service component?   Yes __   No __
   If no, please explain. ________________________________________________

Instructional Organization:
1. Were rounds conducted on a daily basis?   Yes __   No __   N/A __

2. Did you have appropriate patient responsibility?  Yes __   No __

3. Did you have direct supervision of your activities?  Yes __   No __

4. Did the attending(s) give you feedback on your work and thought processes?  Yes __   No __

5. Did you receive enough support from your resident?  Yes __   No __   N/A __

Self Evaluation:
1. Did you obtain the needed information during this rotation? Yes __  No __
   If not, why, and what did you do to change the situation? ___________________________________________________________________

2. Do you feel that you have any areas of weakness in this rotation subject?  Yes __   No __
   If yes, what steps have you/are you taking to reach your educational goals? ________________________________________________________________

3. Did you read an adequate amount on relative medical topics during this rotation?  Yes __   No __
If no, why? How do you suggest improving the amount of your reading?

__________________________________________________________________
__________________________________________________________________

3. Do you feel you integrated OMM enough with your patients? Yes ___ No ___
   If not, why? _______________________________________________________

4. Do you feel comfortable with your OMM skills? Yes ___ No ___
   If no, what are you doing to improve them? ____________________________
   __________________________________________________________________

5. Did you ever feel that your fatigue level was compromising patient care?
   Yes ___ No ___
   If yes, who did you report the problem to? _____________________________
   What was done to address the problem? _________________________________
   If you did not report the problem, why? ________________________________
   ____________________________________________________________________

Clinical Instructor Evaluation: Did the Attending?
1. Emphasize a problem-solving approach? Yes ___ No ___
2. Display genuine interest in teaching? Yes ___ No ___
3. Approach teaching and patient care with compassion and energy? Yes ___ No ___
4. Set realistic goals and objectives? Yes ___ No ___
5. Serve as a role model? Yes ___ No ___
6. Demonstrates current clinical knowledge? Yes ___ No ___
7. Demonstrates good communication skills? Yes ___ No ___
8. Encourage integration of OMM with your patients Yes ___ No ___
9. Effectively teach integration of OPP/OMM Yes ___ No ___
   If no to any of the above, please explain. _______________________________
   ___________________________________________________________________
   ___________________________________________________________________

What do you believe can be done to improve this rotation? ___________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

What feedback would you like to give to the attending? _______________________
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_____________________________________________________________________
_____________________________________________________________________

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Date: _____________
Resident Signature: ________________________________

Date: _____________
Director of Osteopathic Medicine/Program Director