Department of Pediatrics
Resident Evaluation Form
Continuity Clinic

Resident: _____

PGY Level: _____

Supervising Faculty:_____
Rate the resident on a scale of 1 to 5 where: 1 is failing, 2 is needs improvement, 3 is average, 4 is good, a role model for other residents and 5 is exceptional top 90th percentile.

General Medical Knowledge:		**Patient Care:**	
History & Physical Examination:		**Documentation:**	
Procedural Skills:		**Professionalism:**	
Problem Solving & Clinical Judgment:		**Professional Responsibility:**	
Management Plan:		**Interpersonal & Communication Skills:**	
Practice Based Learning:		**Systems Based Practice:**	
Overall Performance:			

1. **Review patient panel every four months with faculty. Add different patients with variety of diagnosis as needed.**
   ☐ **Completed** ☐ **Not Completed**

2. **Review procedures done during four months. (Developmental testing, Inhalation treatment, Immunizations, circumcision, Throat culture etc.)**
   ☐ **Completed** ☐ **Not Completed**

3. **Participation in continuity clinic curriculum.**
   ☐ **Yes** ☐ **No Presentation**

Strengths:

Areas for Improvement: *(Please suggest areas in which resident could use additional experience and development)*

Resident (is / is not) functioning at level acceptable for promotion.

Was this evaluation discussed with the Resident? _____**Yes** _____**No**

Supervisor's Signature: _____ **Date:** _____

Resident's Signature: _____ **Date:** _____
(Resident's signature implies only that you have had an opportunity to review and discuss this form and not that you are in agreement with the evaluation.)