



Office of Admissions

5999 Summerside Drive, Suite 220, Dallas, Texas, USA 75252
 Toll Free 1-888-440-4474 or 972-484-9700 Fax 972-484-9970

Clerkship Performance Evaluation

Name of the Student: _____

Student ID No. (Last 6 digits of SSN): _____ / _____

Date: ____ / ____ / _____ Clerkship: Core / Elective Duration: ____ Weeks

Circle One

Rotation Dates: _____ / _____ Specialty: _____
Start End

Students are scored on a scale of 1 to 5, one being the lowest. A numerical entry of "2" in any of the following categories will result in a grade of "Fail" (F). [check one]

	1	2	3	4	5
Patient Care & Medical Knowledge					
Knowledge of medical sciences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History taking and physical exam skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of assigned patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical/Professional judgment (diagnostic & therapeutic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal and Communication Skills					
Patient interviewing skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effective team member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professionalism					
Appearance, attitude & behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice-Based Learning & Improvement					
Uses information technology for education & patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
System-Based Practice					
Knowledge of multi-disciplinary team approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Physician Signature: _____ Date: ____ / ____ / _____

Printed Name, Degree & Title: _____

Department: _____ Institution: _____

Phone Number: _____ - _____ - _____ E-mail: _____

Address: _____

For Medical College Office Use:

Calculated Grade: _____ Attendance: _____

Verified Logbook: **YES / NO** Write-up Evaluation: _____

Clerkship: **Accepted / Rejected**

Signature: _____ Date: ____ / ____ / _____

Registrar Signature: _____