ABC Hospital

RESIDENT EVALUATION OF ROTATION

S=SATISFACTORY/ U=UNSATISFACTORY

Rotation Director: ____________________ Rotation Title: __________________

Dates of Rotation: ____________________ Resident: __________________

Orientation to Rotation

1. Appropriate length S/ U

Curriculum Structure

2. Competencies Identified S/ U
3. Competencies Met S/ U
4. Reference Materials S/ U
5. Quality of Instruction S/ U
6. Appropriateness to Podiatry S/ U
7. Treated Respectfully S/ U
8. Active Participation S/ U

Rotation Director Signature ______________________ Date _______________

Resident____________________________________ Date _______________

DPME Signature _______________________________ Date _______________

COMMENTS:______________________________________________________

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Revised 4/2012