

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: _____
