

**OHIO UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE  
CLINICAL EXPERIENCES EVALUATION FORM  
CPC 2 Fall Quarter 2009 (developed 8/27/2009)**

**STUDENT:** Print your name here and give to the assigned faculty: \_\_\_\_\_

**FACULTY:** Students are expected to establish learning goals for their clinical experiences. Please select one or more of the following skills as goals you will help the student accomplish.

- \_\_\_\_\_ 1. Interview patients for medical history, chief complaint and psychosocial information.
- \_\_\_\_\_ 2. Demonstrate verbal and non-verbal communication skills used to develop rapport with patients.
- \_\_\_\_\_ 3. Review the medical record and practice writing SOAP notes.
- \_\_\_\_\_ 4. Become familiar with H & P instruments (otoscope, ophthalmoscope, stethoscope, syphgmomanometer).
- \_\_\_\_\_ 5. Begin to identify disorders of the neurological system, ear, eye, nose and throat.
- \_\_\_\_\_ 6. Other: \_\_\_\_\_

**FACULTY:** This portion of the form is to evaluate the student's performance. During these experiences, the student: (Circle One) **S = Satisfactory**    **M = Marginal**    **U = Unsatisfactory**

- S**   **M**   **U**    1. Possessed a fund of medical knowledge appropriate for a second-year medical student; was open-minded to acquiring new knowledge; applied basic science principles.
- S**   **M**   **U**    2. Demonstrated interviewing skills appropriate to a second-year medical student.
- S**   **M**   **U**    3. Used effective listening, questioning and narrative skills to communicate with patients and families; demonstrated cultural sensitivity.
- S**   **M**   **U**    4. Communicated professionally with physicians, other trainees and health care staff.
- S**   **M**   **U**    5. Demonstrated respect, compassion and integrity in relationships with patients, families and colleagues.
- S**   **M**   **U**    6. Demonstrated professional work habits and appearance.

**Comments:** \_\_\_\_\_

**Print your name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

Faculty name (please print): _____	Date: _____
Faculty signature: _____	# Hrs for CME: _____

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Faculty signature: _____	# Hrs for CME: _____

Faculty name (please print): _____	Date: _____
Faculty signature: _____	# Hrs for CME: _____

**Faculty:** Please fax the completed form to the CCE Program at (740) 593-2161; keep a copy for your records.