

**OHIO UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE
CLINICAL EXPERIENCES EVALUATION FORM
PCC 1 Fall Quarter 2009 (developed 8/27/2009)**

STUDENT: Print your name and give to your assigned clinical 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 to obtain medical history, chief complaint and psychosocial information.
- _____ 2. Demonstrate verbal and non-verbal communication skills to develop rapport with patients.
- _____ 3. Practice taking vital signs and writing SOAP notes.
- _____ 4. Become familiar with medical instruments (otoscope, ophthalmoscope, stethoscope, and sphygmomanometer).
- _____ 5. Learn how to examine the abdomen, ears, eyes, 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 first-year medical student; was open-minded to acquiring new knowledge; applied basic science principles.
- S** **M** **U** 2. Demonstrated interviewing skills appropriate to a first-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:** _____

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

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Preceptor signature: _____	# Hrs for CME: _____

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Preceptor signature: _____	# Hrs for CME: _____

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

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