

**OHIO UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE  
CLINICAL EXPERIENCES EVALUATION FORM  
PCC 2 Acute Care 2009-2010 (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. Review new admissions to the hospital or Emergency Department.
- \_\_\_\_\_ 2. Interview patients and families and perform physical exams as appropriate.
- \_\_\_\_\_ 3. Review significant physical and psychosocial findings of patients in the hospital and ER.
- \_\_\_\_\_ 4. Develop appropriate SOAP notes.
- \_\_\_\_\_ 5. Analyze laboratory data.
- \_\_\_\_\_ 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**

- |          |          |          |   |
|----------|----------|----------|---|
| <b>S</b> | <b>M</b> | <b>U</b> | 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. |
| <b>S</b> | <b>M</b> | <b>U</b> | 2. Demonstrated interviewing skills appropriate to a second-year medical student.   |
| <b>S</b> | <b>M</b> | <b>U</b> | 3. Used effective listening, questioning and narrative skills to communicate with patients and families; demonstrated cultural sensitivity.                           |
| <b>S</b> | <b>M</b> | <b>U</b> | 4. Communicated professionally with physicians, other trainees and health care staff.   |
| <b>S</b> | <b>M</b> | <b>U</b> | 5. Demonstrated respect, compassion and integrity in relationships with patients, families and colleagues.  |
| <b>S</b> | <b>M</b> | <b>U</b> | 6. Demonstrated professional work habits and appearance.  |

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

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

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