

**OHIO UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE
CLINICAL EXPERIENCES EVALUATION FORM
PCC 2 Ambulatory Care 2009-2010 (developed 8/27/2009)**

STUDENT: Print your name here 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 develop rapport and determine history and psychosocial information.
- _____ 2. Perform necessary physical exams, using appropriate equipment.
- _____ 3. Construct progress (SOAP) notes on selected patients.
- _____ 4. Perform basic OMM when applicable.
- _____ 5. 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: _____
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.