Office of Admissions
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Toll Free 1-888-440-4474 or 972-484-9700 Fax 972-484-9970

STUDENT EVALUATION OF CLINICAL ROTATION

Preceptor's Name: _____
Last Name First Name Middle Initial

Hospital or Clinic: _____
Name

_____
Street Address

_____
City State Zip Code

Rotation: _____ **Rotation Dates:** _____ – _____
Name of Rotation **Start Date – End Date**

DIRECTIONS: RANK EACH AREA OF YOUR CLERKSHIP USING THE FOLLOWING RATING SCALE. CHECK N/A IF NOT APPLICABLE

SCORING: 5=EXCELLENT 4=GOOD 3=AVERAGE 2=BELOW AVERAGE 1=POOR N/A=NOT APPLICABLE

DISCRIMINATORS	**1**	**2**	**3**	**4**	**5**	**N/A**
PROFESSIONALISM OF PRECEPTOR	☐	☐	☐	☐	☐	☐
ATTITUDE & WILLINGNESS OF PRECEPTOR TO TEACH	☐	☐	☐	☐	☐	☐
ATTITUDE OF OTHER PERSONNEL (NURSES, HOUSE STAFF, ETC)	☐	☐	☐	☐	☐	☐
TEACHING OF DIAGNOSIS & TREATMENT	☐	☐	☐	☐	☐	☐
OBSERVATION OF PROCEDURES	☐	☐	☐	☐	☐	☐
PERFORMANCE OF PROCEDURES	☐	☐	☐	☐	☐	☐
NUMBER OF PATIENT CONTACTS PER DAY	☐	☐	☐	☐	☐	☐
NUMBER OF HISTORY & PHYSICAL EXAMS PER WEEK	☐	☐	☐	☐	☐	☐
SCOPE AND VARIETY OF PATHOLOGY/DISEASE	☐	☐	☐	☐	☐	☐
NIGHT AND WEEKEND COVERAGE	☐	☐	☐	☐	☐	☐
QUALITY OF DIDACTICS (I.E., LECTURES, READING, ROUNDS, ETC.)	☐	☐	☐	☐	☐	☐
OVERALL ROTATION EVALUATION	☐	☐	☐	☐	☐	☐

COMMENTS: Please briefly describe the strongest and weakest areas of this Rotation.
Would you in retrospect take this rotation again? Yes ☐ No ☐

Student Name (optional): _____