**Final Confidential Evaluation Form**

|  |  |
| --- | --- |
| 1. Name:
 |  |
| 1. Specialty/Subspecialty
 |  |
| 1. Program ACGME-Accredited
 | [ ]  **YES** [ ]  **NO** |
| 1. Dates of Training
 |  | To |  |
| 1. Degree/Certificate Granted
 |  | Date |  |
| 1. Is the resident/fellow recommended for admission to the Board Examination in his/her appropriate specialty or subspecialty?
 | [ ]  **YES** [ ]  **NO** [ ]  **N/A** |
| If NO, explain |  |
| 1. Do you verify that the resident/fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice?
 | [ ]  **YES** [ ]  **NO** |
| 1. This evaluation is based on Program Educational Outcomes and demonstrated performance using the final ACGME milestones report and reflects those expectations of a practitioner at similar level of training and experience.

**(Attach final ACGME milestones report for trainee file.)** | [ ]  **YES** [ ]  **NO** |
| 1. During the time noted in #4, has this physician ever been subject to any disciplinary action, specifically probation, suspension, or dismissal?
 | [ ]  **YES** [ ]  **NO** |
| If YES, describe |  |
| 1. Do you know of any malpractice actions instituted or in process?
 | [ ]  **YES** [ ]  **NO** |
| 1. Have you ever observed or been informed of any physical/mental health/drug or alcohol dependencies or other problems which have impaired his/her ability to adequately perform during the training program?
 | [ ]  **YES** [ ]  **NO** |
| If YES, describe |  |

| **Competencies** | **Poor** | **Fair** | **Good** | **Superior** |
| --- | --- | --- | --- | --- |
| Basic Medical Knowledge |  |  |  |  |
| History and Physical Examination |  |  |  |  |
| Record Keeping and Case Presentation |  |  |  |  |
| Patient Management and Care |  |  |  |  |
| Professional Judgment |  |  |  |  |
| Physician-Patient Relationship |  |  |  |  |
| Demonstrated Responsibility and Ethical Conduct |  |  |  |  |
| Cooperativeness, Ability to Work with Others |  |  |  |  |
| Professional Appearance |  |  |  |  |
| Timely Communication with Health Care Team |  |  |  |  |
| Commitment to Continuous Learning and Practice Improvement |  |  |  |  |
| Ability to Practice in and Improve Systems of Care |  |  |  |  |

**RECOMMENDATIONS**

1. Recommended highly without reservation [ ]
2. Recommended as qualified and competent [ ]
3. Recommend with some reservation [ ]
4. Do not recommend [ ]

**If 3 or 4 checked, explain in Comments section or on a separate attachment.**

**Report is based on:**

1. Close personal observation [ ]
2. General Impression [ ]
3. A composite of evaluation by supervisors [ ]
4. Other (explain in Comments section) [ ]

**COMMENTS (Notable strengths and weaknesses or explanation of above answers)**

|  |
| --- |
|  |

| **Completed by:** |  | I have read the foregoing information and have had an opportunity to discuss it with the evaluator. |
| --- | --- | --- |
|  |  |  |
| Print Name |  | Print Name |
|  |  |  |
| Signature |  | Signature of Trainee |
|  |  |  |
| Title |  | Date |
|  |  |  |
| Date |  |  |

|  |  |
| --- | --- |
| After completion of training, the above named individual’s address will be: |  |

(Attach separate sheets if additional space is required, or to provide activity documentation)