**Final Confidential Evaluation Form**

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| --- | --- | --- | --- |
| 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)**

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|  |

| **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)