Appendix F: Clinical Elective Assessment of Student Performance

CRN#: ___|_____

ID#: _____

St. George's University
SCHOOL OF MEDICINE
Grenada, West Indies

Office of Clinical Education Operations

Clinical Elective Assessment of Student Performance

Student's Name: _____

Hospital Name: _____

Address: _____

Elective Name: _____

Rotation Dates: _____/_____/_____ to _____/_____/_____ Number of Weeks: _____

Using specific examples, comment on the student's academic performance, professional behavior, rapport with staff and Patients, motivation, attendance and any other aspects of their performance during the rotation:

_____

_____

_____

_____

_____

_____

Constructive Comments (not for use in MSPE):

_____

_____

_____

Medical Knowledge		
Clinical Skills		
Professional Behavior		

Final Grade: (circle one) Pass Fail

Evaluator _____
Name and Title (Please Type or Print)

Signature _____ Date _____

Affix Official Hospital Seal Over Signatures OR Notarize here.

Director of Medical Education _____
Name and Title (Please Type or Print)

Signature _____ Date _____

Please note that students have the right to view the contents of this evaluation.
Return this Form to: Office of Clinical Education Operations, Attn: Clinical Evaluations
University Support Services, LLC, 3500 Sunrise Hwy, Bldg 300, Great River, NY 11739