



University of Virginia
Department of Psychiatric Medicine

NEUROLOGY

Name of Resident _____

Dates of Service _____

Service Name _____

PGY 1

1	2	3	4	5	6
7	8	9	10	11	12
Rotation #					

Resident Performance Evaluation

Please rate Resident based upon function and knowledge while working on your service or under your supervision. Base this evaluation upon knowledge and performance comparable to peers, with regard for level of training and time of year.

N/A = Not Applicable

Not part of this rotation

1, 2 = Unacceptable

Does not meet minimal skill or knowledge objectives

3, 4 = Marginal

Needs improvement, would benefit from remediation

5, 6 = Average

Customary and usual acceptable performance and knowledge

N/O = Not Observed

Did not observe

7, 8 = Above Average

Performance or knowledge Somewhat above that of peers.

9 = Superior

Performance or knowledge Exceeds expectations

10 = Outstanding

Far exceeds expectations in performance or knowledge.

#	Category of Review	1	2	3	4	5	6	7	8	9	10	N/O	N/A
I	ADMIN. RESPONSIBILITY												
A	Case Management Skills												
B	Organizational Skills and Paperwork												
C	Attendance and Participation												
D	Understanding of Dept/Service Operations												
E	Other ()												
II	NEUROLOGIC KNOWLEDGE												
A	Basic Neurologic Diseases												
B	Pharmacology and Somatic Therapies												
C	Differential Diagnosis												
D	Other ()												
III	PATIENT CARE SKILLS												
A	Patient Presentations												
B	Patient Interview and Assessment												
C	General Physical Diagnosis Skills												
D	Management of Patients												
E	Neurologic Exam												
F	Procedures (LP, Suture, ECT, other)												
G	Other ()												
IV	TEAMWORK												
A	Patient Rapport and Interpersonal skills												
B	Ability to work as part of a team												
C	Flexibility and response to feedback												
D	Attitude toward work												
E	Other ()												
V	ACADEMIC/SUPERVISORY ABILITIES												
A	Works effectively with medical students												
B	Ability to learn new material												
	Use of Literature												
C	Other ()												
VI	OVERALL ASSESSMENT												

Comments:

I have reviewed this evaluation with the resident named above.

Supervisor's Name/ TITLE /Signature

Resident
Initials

RETURN THIS FORM WITHIN 5
DAYS TO:
**RESIDENCY COORDINATOR
PSYCHIATRIC MEDICINE
Melissa, HSC, BOX 800623**