

University of Virginia
 Department of Psychiatric Medicine

Faculty Performance Evaluation

Name of Faculty _____ Name of Service _____

Time of Rotation (circle one) **July -Sept, Oct-Dec, Jan-Mar, Apr-Jun** Year (circle one) **1999, 2000, 2001, 2001**

Please rate the following areas according to the scale listed below:

1=Unacceptable, 2=Minimally Acceptable, 3=Acceptable, 4=Good, 5=Outstanding (Deserves Commendation), 6= Not Applicable

1) Fund of Knowledge	1	2	3	4	5	6
2) Quality of Instruction in						
• Assessment of the Patient	1	2	3	4	5	6
• Case Management	1	2	3	4	5	6
• Milieu Issues	1	2	3	4	5	6
• Psychotherapy	1	2	3	4	5	6
• Use of Medications	1	2	3	4	5	6
3) Administrative Training and Responsibility						
• Attendance at Meetings and Sessions	1	2	3	4	5	6
• Allows Resident the Proper Amount of Responsibility	1	2	3	4	5	6
• Provides Regular Individual Supervision	1	2	3	4	5	6
4) Personal Attitudes						
• Quality as a Role Model	1	2	3	4	5	6
• Encourages Growth of the Resident	1	2	3	4	5	6
5) Overall Assessment	1	2	3	4	5	6

Comments: (helpful and desirable)

Resident's Name/ Signature (Optional)	Date
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FILL OUT AND RETURN IMMEDIATELY TO: Residency Coordinator BOX 800623 UVA Health System