



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												
D	Understanding of Dept/Service Operations												
E	Other ()												
II	PSYCHIATRIC KNOWLEDGE												
A	Therapy and Psychodynamic Issues												
B	Psychopharmacology and Somatic Therapies												
C	Diagnosis in Psychiatry and the DSM IV												
D	Other ()												
III	PATIENT CARE SKILLS												
A	Psychiatric Assessment												
B	Interviewing Skills												
C	Physical Diagnosis Skills												
D	Medical Management of Patients												
E	Use of Psychiatric Medications												
F	Procedures (LP, suture, ECT, other)												
G	Other ()												
IV	TEAMWORK												
A	Interpersonal skills												
B	Ability to work as part of a team												
C	Flexibility and response to feedback												
D	Attitude toward work												
E	Other ()												
V	SUPERVISORY ABILITIES												
A	Works effectively with medical students												
B	Supervision /support of lower residents												
C	Other ()												
VI	OVERALL ASSESSMENT												

Comments:

I have reviewed this evaluation with the resident named above.

Supervising Physician Name / Signature

Resident
Initials

**RETURN THIS FORM
WITHIN 5 DAYS TO:
RESIDENCY COORDINATOR
PSYCHIATRIC MEDICINE
KIM MANN, HSC, BOX 623**