

University of Virginia Dept. of Psychiatric Medicine **ROTATION SITE EVALUATION**

Rotation Type: _____ Name of Rotation site: _____

Resident Name (Optional): _____ Year _____ Summer Fall Winter Spring

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

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|----|--|---|---|---|---|---|---|
| 1. | Facility and Services | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | Patient Breadth | | | | | | |
| 3. | Amount of work | | | | | | |
| 4. | Supervision and Availability of
Preceptor to resident | | | | | | |
| 5. | Didactics | | | | | | |
| 6. | Staff Attitude toward Resident | | | | | | |
| 6. | Strengths of Rotation: | | | | | | |
| 8. | Weaknesses of Rotation: | | | | | | |

Suggestions for improvement:

**FILL OUT AND RETURN RIGHT ASAP TO:
KIM MANN, BOX 623 HSC**