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POSTGRADUATE PRECEPTOR PROGRAM PC521

MONTHLY EVALUATION OF INTERN

Date of Evaluation: _____ For the Month of: _____

Intern Name: _____

Doctor Name: _____

Dates of Preceptorship. From: _____ To: _____ (anticipated last date)

Please respond to each of the following using the scale.

1 - SUPERIOR 2 - ABOVE AVG. 3 - AVERAGE 4 - BELOW AVG. 5 - INADEQUATE

1. _____ The Intern is punctual in meeting commitments.
2. _____ The Intern is thorough and accurate in keeping records on patients in her/his care.
5. _____ The Intern is able to arrive at an accurate diagnostic impression.
6. _____ The Intern plans appropriate treatment and patient follow-up.
7. _____ The Intern's ability to administer an adjustment meets practice standards.
8. _____ The Intern accepts constructive criticism willingly.
9. _____ The Intern demonstrates ethical and professional behavior.
10. _____ The Intern is able to identify when more advanced testing is required.
11. _____ The Intern is able to identify when a referral is needed.
12. _____ The Intern is able to adequately interpret X-ray, lab and other significant exams.
13. For this month, the Intern has about how many patient interactions? _____

14. Please describe what you feel are this Intern's strengths and weaknesses at this time.

Doctor's Signature _____ Date _____

Please fax to (408) 944-6093 on the first of each month.