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.