KNOWLEDGE OF STRUCTURE, FUNCTION, & DISEASE NEUROSCIENCE BACKGROUND & DEVELOPMENT (MK1) NEUROLOGY KNOWLEDGE & DEVELOPMENT (MK2, MK4) PATIENT-SPECIFIC DISEASE KNOWLEDGE (MK2)					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Neuroscience knowledge had major gaps or demonstrated minimal improvement. Not familiar with key concepts from 1st and 2nd year courses, well into the clerkship. Often did not attempt to localize. Not able to answer essential neurology questions, appropriate for 3rd year student. Not able to apply explicitly taught knowledge to a patient with similar circumstances. (e.g. previously rounded on patient with 3rd nerve palsy, but didn't recognize 3rd nerve palsy on own patient admitted overnight) Patient background reading had major gaps sometimes, or minor gaps consistently.	Neuroscience knowledge began slightly below expectations, or did not demonstrate consistent or steady improvement. Required direction for review of neuroanatomy and pathophysiology. Did not consistently localize. Occasionally unable to answer neurology questions appropriate for 3rd year student. Was inconsistent in applying explicitly taught knowledge to new situations. Patient background reading was superficial sometimes, or had minor gaps. Answers may have been vague or overly general.	Began with essential foundation of neurosciences based upon 1st and 2nd year courses, but may have needed to devote additional time for some details. Improved to demonstrate occasional application of neuroanatomy and pathophysiology to patient scenarios during rounds and conference. Knew essential neurology information pertaining to epidemiology, history, exam, and diagnosis. Clearly read about patient's condition and knew essential elements to differentiate key diagnoses and treat most likely condition. Patient knowledge was not always spontaneously integrated or volunteered, but apparent upon questioning. Occasionally, answers may have been more general, rather than specific to the patient.	Began with detailed neuroscience knowledge, permitting opportunities to proactively ask questions and begin to apply neuroanatomy and pathophysiology toward diagnoses. Neurology knowledge detailed and comprehensive, with ability to provide concise and relevant answers for diagnosis and disease management. Thoroughly read on patient's condition. Spontaneously offered highly relevant knowledge for making decisions, and could answer more detailed questions with prompting. Beginning to understand rationale for different diagnostic and treatment approaches.	Pathophysiology and neuroanatomy consistently integrated into work-up and assessment to impact diagnostic prioritization and patient care (i.e. localizes Horner's syndrome to diagnose lung cancer). Appreciated neurological issues for patient management, including controversies, subtle distinctions, or uncommon presentations. Knowledge was always detailed and specific to the patient. Engaged, participatory, and pro-active in learning for all patients on service. Frequently applied previously discussed topics to new situations. Thoroughly read on own patients likely diagnoses, and for many of the other patients on service. Often used EBM principles for management.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

KNOWLEDGE APPLICATION AND CASE SYNTHESIS **PARTICIPATION DURING ROUNDS AND CONFERENCES (PROF 4)** **ABILITY TO SYNTHESIZE INFORMATION FOR DIAGNOSIS AND MANAGEMENT (PC4, PC5, MK4)** **ABILITY TO BUILD UPON PRIOR LESSONS AND EXPERIENCES (PBLI2)** **USE OF LITERATURE & EDUCATING THE TEAM (PBLI3, PBLI4)**					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Unengaged and non-participatory on rounds. May not have showed up to some rounds, left early without explanation, had non-medical side conversations, or other distracting behavior. Case synthesis was lacking, did not get the main idea of the case, or would focus upon tangential issues. History, exam, studies were disconnected. Differential missed some major considerations, or lacked basic rationale and thought process. Often repeated errors or did not integrate experiences and previously discussed knowledge. Primary literature not accessed, even with prompting. Did not do teaching topic, or did a superficial/minimally prepared topic after repeated prompting.	Spoke when called upon, but little spontaneous discussion. Engagement on rounds inconsistent. Or, comments and questions may have been excessive and non-productive. Case synthesis inconsistent, superficial, or contained some gaps. Presentation less relevant despite prior coaching by resident. Differential occasionally missed a prime diagnosis, or patient management was underdeveloped. Sometimes repeated errors. Did not consistently integrate prior experiences and teaching. Needed direction to the literature, or didn't use the literature consistently, or didn't pick articles with patient relevancy. Teaching topic could have been more focused, more comprehensive, higher level of detail, or presented with more engagement.	Engaged with some participation during rounds and conferences. Questions were primarily to acquire fundamental knowledge. Beginning to demonstrate case synthesis by elaborating upon some key elements in the case history and sometimes linking these together with exam and studies. Provided an essential differential with some rationale and consideration of epidemiology. Built upon prior patient-care experiences and teaching to demonstrate improvement. Sometimes used literature for own patients, may have needed guidance. Teaching topic was complete, general overview. (e.g. pathophysiology and clinical course of Bell's palsy).	Always engaged with consistent participation. Observant questions related to patient care to build upon fundamental knowledge. Demonstrated case synthesis by explicitly corroborating and linking key case elements to yield a thorough differential that included most major and some less common considerations. Demonstrated reading and self-study for previous discussions and patient issues which were then applied to future patients. Made list of topics to review from rounds. Independently used relevant literature for own patients and occasionally other patients. Teaching topic logical, concise, included several key references to answer a relevant patient issue (e.g. differential diagnosis for facial palsies, with reference to current patient).	Discussion and questions made positive contribution to team learning and management issues for any patient on the team. Thoroughly understood case to link key case elements, for well rationalized, prioritized differential with all major and many relevant minor diagnoses. Took principles from previous discussion and experiences, and adapted those to new and different patient situations. Routinely sought primary literature to effectively answer key issues for any patient, with examples of impacting patient management. Teaching topic integrated multiple primary references and EBM to thoroughly yet concisely educate the team to impact patient management (e.g. treatment guidelines on prednisone and acyclovir for Bell's palsy).	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

HISTORY AND DATA ASCERTAINMENT **COMPLETE, RELIABLE, DIFFERENTIAL-ORIENTED HISTORY (PC1, MK2)** **PSYCHOSOCIAL BACKGROUND (PC1, MK4)** **GATHERED ANCILLARY DATA (PC1)** **AWARE OF ACTIVE ISSUES (PC1, ICS3, PROF4)**					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
History often had major gaps or inconsistencies. History may have needed to be redone due to missing information or low reliability. Diagnosis was often not evident after the history. Often neglected psychosocial background, health behaviors, and patient perspective. Records not reviewed such that diagnosis and management remained unclear. Sometimes would not contact additional informants, even with prompting. Often not aware of active issues, or needed resident to fill-in gaps for patient progress.	History superficial, had minor gaps, minor inconsistencies, or variability. May say "I don't know" when asked for clarification. Focus may have been on medical opinion and testing rather than patient experience. Superficially explored or occasionally neglected psychosocial issues, health behaviors, and patient perspective. Did not consistently seek corroborating history through family, internal, and outside records. Knowledge of active issues may have occasionally been incomplete, or needed prompting for patient updates.	Appropriate symptom-based history, most often accurate, reliable, and complete for a diagnosis. Some details needed for functional impact and differential. Obtained essential information on psychosocial background and behaviors that influence health; sometimes obtained patient perspective. Thoroughly reviewed all available records. Obtained outside records or spoke to ancillary informants with prompting. Almost always aware of active issues on patients. Spontaneously offered updates on patient progress.	Comprehensive, patient experience-based history. Almost always accurate, reliable, pertinent to differential. Almost always included functional impact. Consistently obtained detailed and sensitive psychosocial background, behaviors, and perspective. Spontaneously sought additional informants when information was missing (i.e. MS changes, LOC). Reviewed many available and outside records (clinic notes, tests, procedures) across different electronic platforms without prompting. Always aware of active issues and developments on their patients. Often continued to follow patients peripherally when off-service.	Student always knew patient best. Supervisors got same story with minimal additional details. Always knew key history for localization and differential. Always incorporated ADLs and functional impact. Full appreciation of patient and family from a psycho-social perspective translated into examples of improved care. Demonstrated sensitivity to ethnicity, cultural, and socioeconomic factors. Spoke to multiple sources to complete history and assess baseline functional status. Resourcefully reviewed all records for precise details on past medical diagnoses, medications and doses, etc. Thoroughness clarified erroneously propagated chart documentation. Always aware of active issues for own patient, and often for other patients. Pro-active approach translated into examples of improved care.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

PHYSICAL EXAMINATION **TECHNIQUE (PC2)** **RELIABILITY (PC2)** **FLEXIBILITY (PC2, PC4)**					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Exam often had gaps in thoroughness. Technique was not correct or well-organized, or did not improve. May have been abrupt or unclear with instructions. Exam often not reliable; missed significant findings. Exam approached like a checklist without sensitivity to patient concerns or comfort.	Screening exam occasionally had gaps in thoroughness. Sequencing often not smooth. Technique and instructions not always most effective. Exam findings were not rechecked and corroborated to ensure accuracy. Reliability may have been variable. Exam incomplete for anxious or uncomfortable patients.	Performed a complete neurologic screening exam for new patients, and an appropriately targeted exam at follow-up. Smooth flow and proper technique ensured major findings were discovered. Instructions conveyed efficiently. Major findings were almost always reliable. Subtle findings were sometimes found but needed clarification to interpret. Focused learning on basic screening exam. Did not incorporate additional signs or new techniques from rounds.	Thorough with extra time corroborating key findings through repeated testing and different techniques. Additional techniques sometimes used when required (e.g. Dix-Hallpike, orthostatics, Jendrassik maneuver). Flow was logical, with clear instructions, and patient encouragement. Instruments were utilized correctly to get semi-quantitative and reproducible measures. Exam was highly reliable with all major findings observed and sometimes subtle findings. Put patient at ease if uncomfortable, immobile, or fatigued. Obtained essential part of the exam when patient less cooperative.	Exam demonstrated ability to think on feet and frequently included items additional to the screening exam for localization (e.g. cortical signs, pathologic reflexes). Flow always smooth, efficient, non-rushed, and communicated confidently. Excellent technique, instruction, and observation such that subtle findings often discovered. Extremely reliable with important findings rechecked and corroborated through other tests. Exam often tailored in a manner to support or refute items on the differential. Able to take the history and build expectations for the exam with additional time spent on key components.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

ORAL PRESENTATIONS **COMPOSURE (ICS3)** **ORGANIZATION AND LOGIC (ICS3)** **ASSESSMENT (PC4, 5, 6)**					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Oral presentations overly casual, insufficiently prepared, superficial, or filled with unnecessary commentary. Read presentation from own or someone else's note. Organization was lacking, essential detail missing, or many irrelevant details offered. Resident needed to contribute a lot to complete the history. Assessment inconsistently provided, or not well prepared. Localization and differential inconsistent, and frequently not well-reasoned.	Sometimes appeared less enthusiastic (e.g. resting head on hand, no eye contact, slouched, read from note). Relied heavily on reading H&P note. Insufficient preparation came across as nervousness, extraneous words, or commentary that impeded effectiveness. Sometimes did not offer chief complaint. Infrequently added pertinent positives and negatives. Organization sometimes lacking. Diagnosis not always apparent after history. Sometimes not clear where the presentation was taking the listener. Assessment may have had significant gaps. Localization sometimes neglected. Differential not always offered or missed an important diagnosis.	Interested and motivated to present. Sometimes presentation could have benefited from more preparation. Sometimes read from their note. Always began with chief complaint, followed by event chronology with occasional use of pertinent positives and negatives. Diagnosis often apparent by end of history. Sometimes included less relevant information, or did not summarize findings for efficiency. Attempted reasonable localization with essential differential. Differential sometimes overly inclusive, or missed an occasional minor diagnosis.	Enthusiastic, prepared, clear, confident, not read from H&P. Concisely conveyed patient experience while being comprehensive with a memorable story. Pertinent positive and negatives were frequent. Event chronology clearly evident. Hx and PE led listener to the differential. Organization and integration apparent across sections. Assessment was concise and logical with accurate localization and relevant differential. Plan spontaneously offered, focused towards getting patient better.	Engaging, even when everyone was tired or extremely busy. Able to focus on the very most important details in a highly organized, logical, concise manner. Able to anticipate the listener's questions at the time the question would arise. Pertinent positives and negatives indicated an impressive understanding and integration. Localization and differential apparent early through sequencing and supporting elements. Exam concise and efficient, with pertinent positives and negatives (e.g. no Horner's sign). Assessment was composed, accurate, demonstrated higher level thought processes by effectively assimilating prior elements with localization and a complete and prioritized differential diagnosis.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

DOCUMENTATION STRUCTURE, LEGIBILITY, TIMELINESS (ICS4) COMPREHENSIVENESS & ACCURACY (ICS4, PC4, PC5)					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Write-ups were often incomplete, superficial, disorganized, tardy, or inaccurate. Sections were superficial, minimal, or missing important data. Messy with unclear handwriting, wrinkled pages, crammed margins, multiple cross-outs. Often neglected summarization or localization. Differential superficial or inadequate. Note sometimes unacceptable to leave in chart.	Sometimes difficult to read, mildly disorganized, or late. Minor omissions throughout. May have not been detailed with PE (e.g. CN 2-12 intact). May not have fixed note based upon discussion for accuracy. Notes may have been inconsistent, with some very good and others needing attention. Localization may often be missing. Assessment and differential needed further elaboration. Thought process not consistently incorporated.	Write-ups were complete, reliable, neat, and timely. HPI had essential detail and chronology, but may have included too much tangential information or missed some minor points. History may not have had logical presentation all the time. Sections may have not been interconnected. PMH included dates and basic details. PE well organized but abnormal findings not always highlighted. Assessment included brief summary, localization, differential, and plan. Differential sufficient, but sometimes overly inclusive or with minor omissions.	HPI was comprehensive yet concise. PMH had key diagnostic details. SH expanded to include psychosocial background. PE/Studies were detailed, but could quickly find abnormalities. The localization, assessment, differential, and plan crystalized the key pieces of the case history with clear logic and thoroughness. Diagnoses were pertinent to the presentation, PE, and test results. Notes communicated basic thought process and progress for other health care members. Notes were helpful to have in the chart.	All sections exceedingly well organized, formatted, comprehensive, concise, and planned. HPI read like you personally spent 20 minutes getting the history. PMH was exhaustive with all details and functional impact. SH was comprehensive with support, living arrangements, financial situation, education, vocation, insurance issues, etc. Assessment clearly demonstrated thought process. Summary statement distilled most critical information, followed by a well-reasoned localization, differential, and plan. Notes were an asset for the chart and the best source to learn about the patient. Medical progress clearly documented. Note could be used as an example for 2nd year students.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

PATIENTS AND FAMILIES RAPPORT (ICS1) EDUCATION AND UPDATING (PC7, ICS2, MK4, SBP2) RESPECT AND ADVOCACY (PROF1, PROF2, PROF3, PROF6, SBP4)					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Interactions with patients and families awkward at times. Did not always perceive social cues. May have unknowingly said things which were inappropriate or insensitive. Did not see patient enough to be effective. Interactions may have been less than the minimum. May have avoided taking a roll as educator and provider of updates. Did not advocate for their patient. Did not seem to go out of the way to help make the hospital stay more efficient. May have made comments about patients that display insensitivity or lack of perspective.	Interactions are sufficient but minimal. Sometimes may have appeared reticent to take the extra step to make connection. May not have reached out to the family even when that would have been important for care. Will keep patients informed when explicitly instructed. Not present when important news is conveyed to their patient. Not consistently pro-active to advocate and to ensure hospital stay was efficient and comfortable. May have expressed frustration or negativity without attempting to remedy a challenging situation.	Established effective rapport with patients. Astute at picking up social cues. Listened carefully without interruption. Acknowledged emotions or difficult situations. Patients identify student as “a nice person and good learner”. Made effort to keep patients and families informed of developments. Sometimes considered social factors when counseling. Sometimes considered patients perspective for shared decision making. Respectful and compassionate for all patients and families. Pro-active and aware of ethical principles governing the student-doctor role.	Enthusiastic and professional demeanor to patients and families. Established commitment through patience, listening, and repeated visits. Patients may have made remarks about the excellent care by their student. Puts patients at ease and created trust. Patients identify student as one of “their doctors”. Consistently kept patients informed and updated, included them in shared-decision making. Advocated for patients during hospital stay. Came back from clinic to ensure patient had updates and questions answered. Often individualized care and information to patient situation. Really tried to understand and remedy situations when patient was anxious or frustrated. Always respectful even under difficult situations or when other healthcare member expressed frustration. Made effort to let patient’s perspective be known.	Remarkable ability to put patients and families at ease under stressful moments. Exhibits patience and empathy. Patients confide important details based upon earned trust. Patients and families explicitly praised the student, remarking on the high level of care and commitment. Patients identify student as “the doctor”. Often sought the family for input and support, even when not physically present. Dedication to patient and family repeatedly led to better care and improved outcomes. Always considered disparities, life-style, culture, and socioeconomic factors. Always kept patients educated and informed, visiting several times per day to do so. Displays utmost respect and compassion, even for the anxious or “difficult” patient. Always seeking ways to ensure patients received the best, most efficient, most comfortable care.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

TEAMWORK AND COMMUNICATION TEAMWORK AND WORK ETHIC (PROF4) RELIABILITY & RESOURCEFULNESS (PC4, PC5) COMMUNICATION (ICS3)					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
Did not always work with team effectively. Reasons might have included passivity, arrogance, impulsiveness, inappropriate interjections, or apparent disinterest. May be looking for first opportunity to leave. Team may not mind if uninterested student was not present, figuring they are better without. Needed to better "take ownership" of patients, or contribute to work for the team. Not able to be relied upon to bring tasks to completion or follow-through on providing optimal care. Seemed to have rushed through things, or cut corners. Did not always keep team apprised of patient developments or personal whereabouts. May not have always communicated with other health care members to be most effective.	Attempted to be helpful, but was inconsistent or did not translate into being organized and effective. Did not keep an active load of patients to follow. May have required step-by-step guide to completing basic tasks. May have often hit "roadblocks" to complete tasks. Reliability and judgment may have been variable. Student was extra work for the team, but was pleasant and willing to try hard. Patient care miscommunication occasionally put the team at a disadvantage. May have been gone for hours with unknown whereabouts. Did not take an interest in patients other than those they directly worked-up.	Helpful to the team. Eager and motivated to assist with patient care. Often asking "What can I do to help?" Could handle most tasks with some appropriate supervision to ensure complete and correct. Making progress towards becoming more independent. Sometimes resourceful to accomplish difficult tasks. Effective at communicating patient care to residents and attendings. Resident always knew their whereabouts. May not consistently communicate with nurses, therapists, case managers, etc.	Ability to observe and adapt to become organized, effective, productive. Interpersonal skills were highly effective and professional. High level of commitment to helping team patients. Kept 'to-do' checklist for patients. Proactive about identifying work within their capacity and getting it done. Beginning to become independent and making continued progress. Ensured patients had education and follow-up at discharge. Always kept team apprised of patient developments. Communicated spontaneously with health care team (i.e. nurses, therapists) to ensure effective care. Would spontaneously speak to families and check with consulting physicians when clarification needed. Always stayed until work was complete or needed to leave for duty hours policy.	Integration was quick and seamless, functioning at full capacity to help. Accepted and sought additional patient care and educational assignments with enthusiasm. Improved patient care due to productivity and interpersonal skills. Took active interest in all patients. Team missed student's contribution when they rotated off-service. Could often self-identify and use excellent judgment in accomplishing tasks. Could be relied upon such that a task was "as good as done". Extremely resourceful in circumventing road blocks. Communication exemplary with all members of health care team (i.e. nurses, techs, unit secretary, therapists, social worker, and case coordinator).	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

PROFESSIONALISM, PERSONAL DEVELOPMENT, AND JUDGMENT FEEDBACK (PBL2) DEDICATION & INITIATIVE (PBL2, PROF4) APPEARANCE (PROF1)					
CLEARLY BELOW EXPECTATIONS	**SLIGHTLY BELOW EXPECTATIONS**	**MEETS EXPECTATIONS**	**EXCEEDS EXPECTATIONS**	**GREATLY EXCEEDS EXPECTATIONS**	
Needs Improvement	**Marginal**	**Reporter**	**Interpreter**	**Manager**	
May have become defensive or resistant to feedback, or gave impression that they were overconfident in abilities and feedback was not valid. Dedication not always apparent based upon timeliness, preparation for rounds, follow-through on tasks. Appeared to often either arrive late or leave early. May have been overly passive, looking to get things done too quickly, or get by with just the minimum effort. Would sometimes appear unprofessional with regards to personal appearance and dress.	Feedback inconsistently integrated. Occasionally needed to be told something repeatedly. Dedication and preparedness was inconsistent. Not always able to identify tasks, or may have needed a high level of guidance and checking-up to ensure completion. Sometimes appeared unprepared or bored. May have been inconsistent in carrying an active load of patients or doing more than the minimum required. Dress may be inconsistent or overly casual. Would sometimes be late or unprepared. Might leave without explanation.	Receptive to feedback, demonstrating integration and improvement. Respectful to all physicians, patients, and families. Dedicated and motivated to improve and do best for patients. Eager to accept new patients and responsibilities. Looked for ways to help. Reliable at accomplishing most tasks. Appearance and dress typically professional and appropriate. Punctual, budgeted time for pre-rounds, and stayed until work was complete. Let others know their whereabouts.	Routinely sought feedback which translated into steep trajectory of improvement. Respectful to all members of the healthcare team, even when fatigued or stressed. Dedication was apparent by staying until work was complete (per duty hours), being well-prepared, and responsive. Pro-active approach to patients and education benefitted their skills and enhanced their role. Always reliable to bring tasks to full completion. Very effective at identifying tasks they could accomplish, working at appropriate level of competence and independence. Appearance and demeanor exceedingly professional.	Exceedingly mature and pro-active approach to feedback, rapidly incorporating comments (formal and informal) from all team members. Total commitment for the rotation and their education with mature and pro-active approach towards all patients on the team. Initiative, confidence, and interpersonal skills point to a potential role as a future leader. Demonstrated grace under fire to accomplish tasks effectively. Always identifying ways to improve the process. Always ensuring that everything has been done optimally. Positive and pro-active attitude impacted patient care and level of education.	Unable to Judge
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐
COMMENTS:					

FORMATIVE ASSESSMENT (Feedback to take forward):
SUMMATIVE ASSESSMENT (Descriptor of capabilities and achievements):