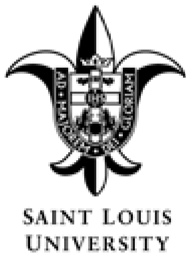

School of Medicine
Graduate Medical Education

THIS IS THE FINAL EVALUATION FOR THE INDIVIDUAL INDICATED. IT WILL BE PROVIDED BY THE OFFICE OF ACADEMIC RECORDS IN RESPONSE TO REQUESTS FOR INFORMATION ACCOMPANIED BY WRITTEN PERMISSION OF THE INDIVIDUAL EVALUATED.

FINAL CONFIDENTIAL EVALUATION FORM

I. 1. Name (Type or Print):____
2. Type of Training: Residency_____ Subspecialty Residency_____ Fellowship____
3. Dates of Training: __________________ to ____
4. Degree/Certificate granted: ________________________________Date: _________________
5. Specialty/Subspecialty:____
6. Program accredited by the Accreditation Council for Graduate Medical Education? Yes ___ No ___
7. Is the applicant recommended for admission to the Board Examination in his/her appropriate specialty or subspecialty?

Yes _____ No _____ Not Applicable _____

If the answer is NO, please explain on a separate attachment.

II. Do you verify that the resident has demonstrated the competencies to enter independent practice?

Yes ___ No ___

III. Evaluation (**Attach final ACGME milestones report for trainee file**.)

Yes ___ No ___ This evaluation is based on Program Educational Outcomes and demonstrated performance using the final ACGME milestones report and reflects those expectations of a practitioner at similar level of training and experience.

	Poor	**Fair**	**Good**	**Superior**
Basic Medical Knowledge				
History and Physical Examination				
Record Keeping and Case Presentation				
Patient Management and Care				
Professional Judgment				
Physician-Patient Relationship				
Demonstrated Responsibility and Ethical Conduct				
Cooperativeness, Ability to Work with Others				
Professional Appearance				
Timely Communication with Health Care Team				
Commitment to Continuous Learning and Practice Improvement				
Ability to Practice in and Improve Systems of Care				

Saint Louis University School of Medicine
Graduate Medical Education, Final Evaluation Form

Name: ____

IV.

1. During the time noted in Item I, has this physician ever been subject to any disciplinary action, specifically reprimand, probation, suspension or dismissal? Yes ____ No ____
   If the answer is YES, please give details in Item VII or on a separate attachment.

2. Do you know of any malpractice actions instituted or in process? Yes ____ No ____

3. Have you ever observed or been informed of any physical/mental health/drug or alcohol dependencies or other problems which have impaired his/her ability to adequately perform during the training program.
   Yes ____ No ____
   If the answer is YES, please explain in Item VII or on a separate attachment.

V. Recommendations

1. Recommended highly without reservation ___
2. Recommended as qualified and competent ___
3. Recommend with some reservation ___
4. Do not recommend ___

If 3 or 4 checked, please explain in Item VII or on a separate attachment.

VI. Report Is Based On

1. Close personal observation ___
2. General Impression ___
3. A composite of evaluation by supervisors ___
4. Other (explain in Item VII) ___

VII. Comments (Notable strengths and weaknesses or explanation of above answers)

____
____
____

Completed by:

____
Print Name

____
Signature

____
Title

____
Date

I have read the foregoing information and have had an opportunity to discuss it with the evaluator.

____
Print Name

____
Signature of Trainee

____
Date

After completion of training, the above named individual's address will be:

____
Street City State Zip

(Attach separate sheets if additional space is required, or to provide activity documentation)

Revised 5/2022