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 sufficient competence to enter practice without direct supervision?**

   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.

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<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Superior</th>
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<td>Basic Medical Knowledge</td>
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<td>History and Physical Examination</td>
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<td>Record Keeping and Case Presentation</td>
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<td>Physician-Patient Relationship</td>
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<td>Demonstrated Responsibility and Ethical Conduct</td>
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<td>Commitment to Continuous Learning and Practice Improvement</td>
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<td>Ability to Practice in and Improve Systems of Care</td>
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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: I have read the foregoing information and have had an opportunity to discuss it with the evaluator.

_________________________________________________  ___________________________________________________
Print Name Print Name
_________________________________________________  ____________________________________________
Signature Signature of Trainee

_________________________________________________
Title
_________________________________________________
Date
_________________________________________________
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)