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. Name (Type or Print):

<table>
<thead>
<tr>
<th>Type of Training: Residency</th>
<th>Subspecialty Residency</th>
<th>Fellowship</th>
</tr>
</thead>
</table>

3. Dates of Training: __________ to __________

4. Degree/Certificate granted: __________ Date: __________

5. Specialty/Subspecialty: __________

6. Program accrediting 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
This evaluation should be based on Program Educational Outcomes and demonstrated performance compared to that reasonably expected of a practitioner at similar level of training and experience.

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

1 of 2
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)