

Front:

Medical Student ED Shift Evaluation Sheet

Student Name: _____ Date: _____

Attending Name: _____ Hours: _____

What were your goals for the student during the ER shift (check all that apply)

// observation of procedures and critical care management

// “shadowing” of supervising staff

// direct patient care (history taking, physician examination, precepting)

// joint patient management with ED resident

// other (write in)

Did the student meet these goals? Yes No

One strength _____

One weakness _____

Does the student’s performance today support an honors evaluation? Y N

Other comments

Mail to: Pediatric Medical Student Office,
CHRMC, 359300/CH-43
Room H517

Back:

Send To:

Pediatric Medical Student Office,
CHRMC
Box 359300 / Mailstop 5H-7
Room H517

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