

**Subject:**

**Evaluator:**

**Site:**

**Period:**

**Dates of Course:**

**Course:** Eval Preview

**Form:** Medical Student of Clerkship

**Clarity of course goals and objectives:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Usefulness of written/electronic materials (e.g. syllabus, text, handouts, readings):** *(Mandatory)*

Not applicable (no assigned readings)	Very Poor	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5	6

**Overall quality of faculty teaching:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Overall quality of resident teaching:** *(Mandatory)*

Not applicable (no residents)	Very Poor	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5	6

**Quality of formal teaching (i.e. seminars, didactics):** *(Mandatory)*

Not applicable (no seminars or didactics)	Very Poor	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5	6

**Overall contribution to your basic medical education:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Clerkship as a whole:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Time spent by faculty and or residents in direct observation of my skills:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Adequacy of feedback from educators throughout the rotation:** *(Mandatory)*

Very Poor	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6

**Did you receive mid-clerkship feedback from a preceptor?** *(Mandatory)*

Selection	Option
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

**Please comment on the quality and quantity of feedback you received during this rotation, and/or suggestions for improvement in this aspect.**

**On this rotation, how often did you take primary responsibility for patient care?** *(Mandatory)*

Never	Very Rarely	Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5	6

**On this rotation, how often did you feel like an integral part of the care team? (Mandatory)**

Never	Very Rarely	Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5	6

**Please comment on the extent of your responsibility for patient care, and/or suggestions for improvement in this aspect of your experience in this clerkship.**

**I was provided an opportunity to interact in a meaningful way with other health care professionals (e.g. dentists, nurses, pharmacists, physician assistants, social workers, etc.) (Mandatory)**

Not Applicable	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
0	1	2	3	4	5

**Please indicate the other professionals with whom you interacted, and describe the interaction.**

**Was your experience in this clerkship in compliance with the SOM's clerkship duty hours policy? (Mandatory)**

(No more than 80 hours awake time in the hospital or clinic per week. Other details are in the SOM Student Handbook.)

Selection	Option
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

**If you answered no to the previous question, please explain below:**

**What were the best things about this clerkship?**

**What do you recommend changing or improving to make this clerkship a better experience for future students?**