POZNAŃ UNIVERSITY OF MEDICAL SCIENCES, POLAND
DEAN OF MEDICAL FACULTY II

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ELECTIVE EVALUATION FORM

Name of Student: _____

Medical School _____

School Address _____

Elective: _____
Course/Code number, Name, etc

Total Number of Weeks Spent in (clinical) (research) Training on this Elective: _____

Date of Elective: Started _____ Completed _____
Month/Day/Year Month/Day/Year

Grade (circle one): Honors High Pass Pass Marginal Pass Fail

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PLEASE, GIVE DETAILED COMMENTS (IF APPLICABLE) ABOUT THE FOLLOWING PARAMETERS

Attitude: _____

Level of professional maturity: _____

Ability to relate to patients: _____

Ability to work with other team members/colleagues: _____

Acceptance of responsibility: _____

Level of practical knowledge: _____

Quality of patient work-ups and presentations: _____

Level of theoretical knowledge: _____

Ability to accept constructive criticism: _____

In what area(s), not listed, does the student need to improve? _____

Additional Comments: _____

(Please use back of form if necessary)

_____

_____

_____

_____

_____

_____

_____
Name and Title of Authorized Official Phone No. Date

THANK YOU FOR YOUR CO-OPERATION