



FAMILY MEDICINE RESIDENCY PROGRAM

DAILY EVALUATION FORM FOR EVENING AND WEEKEND SHIFTS

DATE : _____

NAME OF RESIDENT: _____ **OMSB No :** _____

Level (R): _____ **TRAINING CENTER:** _____

Criteria	Below Average	Average	Above Average	Excellent	Not applicable
Demonstrates factual knowledge					
History and physical examination					
Interpretation & utilization of information					
Clinical judgment & decision making					
Organization of work					
Records Keeping Skills					
Communication Skills					
Responsibility & self-discipline					
Global Evaluation					

COMMENTS (including strengths and weaknesses):

NAME AND TRAINER'S SIGNATURE: _____