

DEPT. OF CARDIOLOGY FELLOW PERFORMANCE EVALUATION

(Please PRINT all information.)

Fellow must complete the information in the below box. Evaluator must complete rest of form and sign at bottom of page 2.

NAME: _____ **ROTATION MONTH/NAME:** _____

ROTATION NAME/SPECIALTY: CARDIOLOGY

DATES OF ROTATION (MM/DD/YY): _____ **to** _____

HOSPITAL (circle one): **KMH-CH** **KMH-ST** **KMH-WT** **OLOL-C** **OLOL-R**

HOSPITAL/SITE (if above location is "other"): _____

Fill in the circle for each competency to indicate your evaluation of the fellow using the below scale:

Any ranking of "Poor" or "Below Average" must be accompanied by comments under remarks on page 2 of the form

NA = NOT APPLICABLE **1 = POOR** **2 = BELOW AVERAGE** **3 = AVERAGE** **4 = ABOVE AVERAGE** **5 = EXCELLENT**

NA	1	2	3	4	5
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Osteopathic Philosophy and Osteopathic Manipulative Medicine:

- | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Demonstrated competency in his/her understanding and application of OMT. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Integrated Osteopathic concepts and OMT into patient care as appropriate. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Understood and integrated Osteopathic Principles and Philosophy into clinical and patient care activities as appropriate. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Medical Knowledge:

- | | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Demonstrated competency in the understanding and application of clinical medicine to patient care. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Knows and applies the foundations of clinical and behavioral medicine. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Patient Care:

- | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Gathered accurate, essential information from all sources, including histories and physical exams, medical records, diagnostic/therapeutic plans, and treatments. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Validated competency in the performance of diagnosis, treatment, and procedures. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Provided health care services consistent with osteopathic philosophy, including preventative medicine and health promotion based on current scientific evidence. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Interpersonal and Communication Skills:

- | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Demonstrated effectiveness in developing appropriate doctor/patient relationships | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Exhibited effective listening, written, and oral skills in professional interactions with patients, families, and other health professionals. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Professionalism:

- | | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Demonstrated respect for his/her patients and families and advocated for the primacy of his/her patient's welfare and autonomy. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Adhered to ethical principles in the practice of medicine. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Demonstrated awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Practice-Based Learning and Improvement:

- | | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Treated patients in a manner consistent with the most up-to-date information on diagnostic and therapeutic effectiveness. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Performed self-evaluations of clinical practice patterns and practice-based improvement activities using a systematic methodology. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Understood research methods, medical informatics, and the application of technology as applied to medicine. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Systems-Based Practice:

- | | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Understands national and local health care delivery systems and how they affect patient care and professional practice. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Advocated for quality health care on behalf of his/her patients and assisted them in their interactions with the complexities of the medical system. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Please Complete Both Pages of the Form

DEPT. OF CARDIOLOGY PERFORMANCE EVALUATION (Page 2)

Fellow must complete the information in the below box. Evaluator must complete rest of form and sign at bottom of page 2.

NAME: _____ **ROTATION DATE:** _____

REQUIREMENTS OF SERVICE:

1. Medical Records obligations completed?: _____ YES _____ NO _____ IN PROGRESS
2. Department/Service educational programs completed?: _____ YES _____ NO
3. Has Fellow made appropriate progress on this rotation?: _____ YES _____ NO

If the answer to any of these questions is "NO", explain below under "Remarks". Include any required remediation (if applicable).

WRITTEN COMMENTS (Please **PRINT** all information.):

Strong Points: _____

Weak Points/Areas for Improvement: _____

Remarks (Mandatory if score of "below average" or "poor" on front or answer of "no" above): _____

Evaluator must complete this box and sign below.

OVERALL ASSESSMENT OF FELLOW (Circle One):

POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT
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Primary Evaluator

Print Name **Date**

Fellow Signature (After Review)

Print Name **Date**

RETURN FORM TO: SJHG 3001 Chapel Ave. Suite 101 Cherry Hill NJ 08002 Attn: Kate Jurman FAX: 856-667-6588

FELLOWSHIP PROGRAM OFFICE USE ONLY:

Reviewed by Program Director

Reviewed by Program Coordinator:

Signature **Date**

Initials **Date**