



COLLEGE OF MEDICINE SHAQRA UNIVERSITY

INTERNSHIP EVALUATION FORM

Intern Name: _____ I.D #: _____

INFORMATION ABOUT THE HOSPITAL WHERE THE ROTATION IS CARRIED OUT

Hospital Name: _____

Rotation : _____

Supervisor (Consultant name): _____

Contact No: _____ Email: _____

ASSESSMENT:

Domain	Fail < 60	Pass 60- <70	Good 70- <80	Very Good 80 - < 90	Excenent 90-100
A : Clinical Management					
History Taking and Physical Examination skills					
Ability to Constructs the differential diagnosis and outline the investigation and management					
B : Medical Practice					
Demonstrates evidence of self-learning					
Gives comprehensive case presentation, Practices the principles of patient safety					
Shows intereste in learning and clinical practice					
C: Communication Skills					
Relation with patient and/or family					
Communicates effectively with the team and others					
D : Professionalism					
Punctuality and attendance					
Responsibility and Attitude					
Self-confidence and acknowledges own limitations and seeks assistance					
Overall Assessment :					

Days attended: _____ Total Days: _____ Days off (permitted leaves) : _____

Supervisor's feedback/ advice/ comments:

Supervisor's Signature: _____ Stamp: _____

Date: _____

Intern 's Signature: _____

To be returned to:

Internship unit

Fax:

Cell: