ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
DEPARTMENT OF SURGERY

Evaluation Form for Surgical Residents & Surgical Attendings

NAME OF PHYSICIAN BEING EVALUATED:	
EVALUATION DATE: _____/_____/_____	☐Intern ☐Resident ☐Attending ☐Fellow

STUDENT CLERK:	☐CCOM ☐CMS ☐UIC ☐_____
ROTATION DATES:	CURRENT YEAR: ☐M3 ☐M4

1. Quality of Teaching

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

2. Average cumulative time spent daily in teaching activities with you

Poor	Fair	Average	Good	Outstanding
None	Less than 30 minutes	30 minutes a day	Less than one hour	An hour or more

3. Quality of supervision

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

4. Organizational Skills

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

5. Teaching in the Operating Room

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

6. Stimulation of you to learn

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

7. Providing Feedback

Poor	Fair	Average	Good	Outstanding
0	1	2	3	4

Would you recommend Physician being evaluated to other students	☐YES ☐NO	**Would you have this Physician as your doctor**	☐YES ☐NO

COMMENTS:

PLANS FOR RESIDENCY: