Resident/Fellow Summative Evaluation

NOTE: This confidential final written evaluation will be maintained in the permanent personnel record of the resident/fellow and used to verify training for outside agencies.

Resident/Fellow Name: ________________________________________________________________

Residency/Fellowship Program: ____________________________________________________

Inclusive Dates of Training: From: ______________________ To: _______________________

The following is derived from a composite of multiple evaluations by the program director and the program’s clinical competency committee. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies and the specialty-specific Milestones, which define the essential components of clinical competence.

In addition to completing the chart below, please attach a summary of resident milestone scoring for final ACGME report.

<table>
<thead>
<tr>
<th>Core Competency</th>
<th>Description</th>
<th>Milestone Level</th>
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</thead>
<tbody>
<tr>
<td>Patient Care:</td>
<td>Provides compassionate, appropriate, and effective patient care for the treatment of health problems and the promotion of health.</td>
<td>1   2   3   4* 5</td>
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<tr>
<td>Procedural Skills:</td>
<td>Demonstrates competence in performing all medical, diagnostic, and surgical procedures considered essential for the area of practice.</td>
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<tr>
<td>Medical Knowledge:</td>
<td>Demonstrates knowledge about established and evolving biomedical, clinical, epidemiological and social behavioral sciences as well as the application to patient care.</td>
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<tr>
<td>Practice-Based Learning and Improvement:</td>
<td>Demonstrates the ability to investigate and evaluate patient care practices, appraises and assimilates scientific evidence to continuously improve patient care based on constant self-evaluation and life-long learning.</td>
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<tr>
<td>Interpersonal and Communication Skills:</td>
<td>Demonstrates interpersonal and communication skills that result in effective information and exchange and collaboration with patients, their families, and health professionals.</td>
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<tr>
<td>Professionalism:</td>
<td>Demonstrates a commitment to carrying out professional responsibilities, and adherence to ethical principles.</td>
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<tr>
<td>Systems-Based Practice:</td>
<td>Demonstrates awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on other resources in the system to provide optimal health care.</td>
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</tbody>
</table>

*Expected level at graduation for most milestones

Milestone scoring comments to explain scores below 4:
Resident/Fellow performance during the final period of training (check the appropriate box):

☐ Satisfactory  ☐ Unsatisfactory

Verification of Training (complete the appropriate response and check the box):

☐ Based on a composite of multiple evaluations, the Program Director and the Clinical Competency Committee of The George Washington University School of Medicine and Health Sciences attest that the training program has been successfully completed and the resident/fellow has demonstrated sufficient competence to enter practice without supervision in the specialty of ___________________________________________________________.

☐ Based on a composite evaluation, the Program Director and Clinical Competency Committee of The George Washington University School of Medicine and Health Sciences attest that the resident/fellow has successfully completed _____ months of the training program.

☐ The resident/fellow has NOT successfully completed the training program.

Disciplinary Action (check the appropriate box):

☐ During the dates of training at this institution, the resident/fellow was not subject to any institutional disciplinary action.

☐ During the dates of training, the resident/fellow was subject to disciplinary action as follows (please describe in the space below or attach a separate sheet):

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Professionalism (check the appropriate box):

- [ ] During the dates of training, the resident/fellow did not show any signs of behavior, drug or alcohol problems.
- [ ] During the dates of training, the resident/fellow did showed signs of behavior, drug or alcohol problems (please describe in the space below or attach a separate sheet):

Clinical Procedures/Privileges Requested (check the appropriate box):

- [ ] The resident/fellow was recommended for the certifying examination administered by the applicable Medical Specialty Board.
- [ ] At the conclusion of training the resident/fellow was judged capable of performing the following procedures independently (please list in space provided or attach list):

Comments:

Program Director Name/Signature/Title ______________________ Date ____________