

---

# RESIDENT'S EVALUATION OF THE RESIDENCY PROGRAM

## Instructions:

One copy of this evaluation must be mailed to NCOPE, 330 John Carlyle St., Suite 200, Alexandria, VA 22314 within 60 days of completion of the residency program. Failure to submit the evaluation will result in a delay in reporting to ABC your successful completion of a residency program.

Residency Program:

---

Residency Director:

---

Resident Name:

---

Training Period: From \_\_\_\_\_ to \_\_\_\_\_

Note to Resident: Please identify and evaluate your residency director and residency program in general. If some faculty deviated markedly (positive or negative) from your overall evaluation, please specify this instructor and describe the situation. Use the following scale:

1 = Always   2 = Often   3 = Occasionally   4 = Rarely   5 = Never   N.A. = Cannot Judge

<u>Teaching Effectiveness</u>	<u>Rating</u>	<u>Attitude</u>	<u>Rating</u>
Gave feedback on my performance		Exhibited supportive behavior	
Encouraged independent thinking		Encouraged and was available for interaction	
Discussed other points of view objectively		Exhibited enthusiasm in teaching and patient care	
Allowed responsibility in managing patients and procedures		Communicated well with me	
Was thorough enough		Communicated well with patients	
Uses documentation (data) to support decisions			

---

A. What were the strengths of your residency training?

B. What were the weaknesses of your residency training?

C. Was it a good experience?

D. What are your practice plans after completion of the residency?

\_\_\_\_\_  
Resident's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Residency Director's Signature

\_\_\_\_\_  
Date