**UNIVERSITY OF MANITOBA - FACULTY OF MEDICINE**  
**ROYAL COLLEGE EMERGENCY MEDICINE TRAINING PROGRAM**  
**In-Training Evaluation Report**

(Type or print, and score appropriately)

**NAME OF RESIDENT:**

**ROTATION:**

**PERIOD(S):**

**DATES:**

**HOSPITAL:**

**PROGRAM DIRECTOR:** Dr. Wes Palatnick

**Evaluation Codes:** 1 - Unsatisfactory, 2 - Below Average, 3 - Average/Good, 4 - Above Average, 5 - Outstanding

**CRITERIA:**

1. **COMMUNICATOR:**
   - N/A 1 2 3 4 5
   - 1. Can consistently present history and physical findings to the attending physician in an organized manner.  
     - 2. Charts are legible, focused and contain all pertinent information.  
     - 3. Can provide other staff, patients and family with a clear discussion of the diagnosis, treatment plan and follow-up.

2. **MEDICAL EXPERT:**
   - **A) Knowledge**
     - 1. Basic science.  
     - 2. Clinical judgement and decision-making.  
     - 3. Basic knowledge.  
     - 4. Emergency Medicine literature.  
   - **B) Skills**
     - 1. Physical Exam.  
     - 2. Choice, use and interpretation of investigations.  
     - 4. Resuscitation skills.  
     - 5. Able to formulate an appropriate differential diagnosis.  
     - 6. Able to arrive at a reasonable working or final diagnosis.

3. **COLLABORATOR:**
   - 1. Works effectively with all members of the health care team.  
   - 2. Maintains a high quality professional relationship with patients and/or family.  
   - 3. Is aware of the cost of health care services.

4. **MANAGER:**
   - 1. Uses time effectively.  
   - 2. Keeps the Emergency Department organized.  
   - 3. Prioritizes.  
   - 4. Supervises others well.

5. **SCHOLAR:**
   - 1. Identifies gaps in knowledge and expertise and works to correct them.  
   - 2. Uses the medical literature in clinical practice.  
   - 3. Teaches others.

**PLEASE SEE REVERSE SIDE**
6. PROFESSIONAL:      N/A  1  2  3  4  5

1. Has a good sense of responsibility.  □ □ □ □ □ □
2. Motivation and ability to learn.  □ □ □ □ □ □
3. Dependability/punctuality.  □ □ □ □ □ □
4. Behaves in a professional manner.  □ □ □ □ □ □
5. Deals with ethical issues such as truth-telling, confidentiality and end of life care.  □ □ □ □ □ □

7. HEALTH ADVOCATE:

1. Considers the social determinants resulting in ED presentation.  □ □ □ □ □ □
3. Able to balance effectively the reasonable needs of the individual patient with available resources and the need for the department to run effectively.  □ □ □ □ □ □

BASIS FOR ASSESSMENT

1. Assessment was based on contact with:  a) one physician ________ b) a group of physicians ________

2. Contact time - estimated contact time between trainee and Attending Physician(s).
   Weeks _______       Hours _______       Shifts _______

3. Estimate number of trainee’s:
   a) Records reviewed           ________
   b) Histories reviewed         ________
   c) Examinations witnessed     ________

4. Do you consider that this resident has successfully completed the objectives of this rotation?
   YES □        NO □

5. Was this evaluation discussed with the resident?       YES □        NO □

COMMENTS (Please write or type clearly)

STRENGTHS: ___________________________________________________________________________________
________________________________________________________________________________________________

WEAKNESSES: ___________________________________________________________________________________
________________________________________________________________________________________________

RECOMMENDATIONS: ___________________________________________________________________________

OTHER COMMENTS: ____________________________________________________________________________

________________________________________________ _________________________________________
Evaluator's Signature                                                                                                  Title
_______________________________________________ _______ __________________________________
Please print name                                                                                                         Date

TRAINEE’S ATTESTATION:  I HAVE SEEN THIS REPORT, AND I :  ACCEPT IT □        DO NOT ACCEPT IT □

_______________________________________________  ________________________________________
Resident's Signature                                                                                                    Date

PLEASE RETURN COMPLETED FORM TO: Department of Emergency Medicine, Julianna Van de Beuken, Program Asst, T258- 770 Bannatyne Avenue, Winnipeg, MB, R3E 0W3