STUDENT CLERKSHIP QUESTIONNAIRE

Caribbean Medical University
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This form is to be completed and returned to the Clinical Department by fax or mail.

STUDENT INFORMATION

TO BE COMPLETED BY THE STUDENT

1 Student's Full Name: _____
Last/Family Name/Surname *First/Given/Personal* *Middle*

ROTATION DATA

TO BE COMPLETED BY THE STUDENT AT THE END OF THE ROTATION

2 Rotation Name: _____ Core ☐ Elective ☐

3 Preceptor's Full Name: _____ Position _____
Last and First Name

4 Site: _____

5 Rotation Dates: / / / / Weeks Completed: __ __
Start Date (mm/dd/yy) *End Date (mm/dd/yy)*

SUMMARY

6 Please describe the preceptor's strongest & weakest areas. Do you beleive the preceptor can improve in anyway?

7 Please describe the strongest & weakest areas of this rotation?

8 Would you recommend this preceptor/rotation? Why or Why Not?

9 Overall Feedback: *(Concerns/Sugestions/Compliments)*

Feedback

10 Feedback Chart

Using a scale of 1-5, please rank the preceptor and rotation based on your experience.

please darken bubble	excellent	good	average	below average	poor	N/A
Preceptor's Professionalism	5	4	3	2	1	0
Willingess to Teach	5	4	3	2	1	0
Attitude of Preceptor	5	4	3	2	1	0
Provided Constructive Critism	5	4	3	2	1	0
Empathetic with Patients	5	4	3	2	1	0
Communication with Staff	5	4	3	2	1	0
Adequate Patient Interaction	5	4	3	2	1	0
Safe Learning Environment	5	4	3	2	1	0
Participation in Procedures	5	4	3	2	1	0
Attended Lectures/Rounds	5	4	3	2	1	0
New Knowledge & Skills	5	4	3	2	1	0
Rotation Objectives Met	5	4	3	2	1	0

Please note that all clerkship questionnaires are for internal use only and will not be released to the preceptor or clinical site. The questionnaires will be used for quality assure and program enchancement purposes.

Students's Signature _____ Date __ __ /__ __ /__ __

FOR OFFICE USE ONLY		
Date	**Staff Member**	**Remarks**