



Department of Emergency Medicine
Student Shift Evaluation

Check one: NYMC NYCPM VSAS

Student Name: _____ **Date of Shift:** _____

	POOR					EXCELLENT					N/A
Presentations	1	2	3	4	5	6	7	8	9	10	
Communication – patients/families/staff	1	2	3	4	5	6	7	8	9	10	
Knowledge Application	1	2	3	4	5	6	7	8	9	10	
Independence	1	2	3	4	5	6	7	8	9	10	
Technical Skills	1	2	3	4	5	6	7	8	9	10	
Professionalism	1	2	3	4	5	6	7	8	9	10	
Fit For Program	1	2	3	4	5	6	7	8	9	10	
Strengths:											
Needs Improvement:											
How would you rank this student in <u>our</u> program?	No rank	Bottom 1/3	Middle 1/3	Top 1/3	Top 10%						

Evaluator name (please print): _____

Evaluator Signature: _____