WEILL CORNELL MEDICAL COLLEGE
Elective Student Assessment

NAME OF STUDENT _____ Indicate your Class: _____

ELECTIVE NUMBER: _____ ELECTIVE TITLE _____

LOCATION: _____

DATES OF ROTATION: _____

ACADEMIC PERFORMANCE	N/A	Poor	Satisfactory	Good	Superio
1. Knowledge of relevant content					
2. Ability to utilize relevant basic science knowledge					
3. Ability to reason					
4. Ability to read & study independently					
CLINICAL PERFORMANCE					
1. Ability to obtain an accurate history					
2. Ability to perform competent physical examination					
3. Ability to give a concise presentation					
4. Ability to formulate differential diagnosis					
PROFESSIONALISM					
1. Acceptance of feedback					
2. Motivation					
3. Reliability					
4. Professional demeanor					
5. Teamwork					
6. Patient rapport					
7. Relationships with faculty					
8. Relationships with other health professionals					

Narrative Comments (please use reverse if necessary):

Overall Grade: Pass_____ Fail_____ Reported by: _____ Date _____
(signature of evaluator)

Name/Title: _____
(type or print)

***These forms should be completed and returned by a faculty member via email or hardcopy.**

Please return completed form to:

Registrar, Weill Cornell Medical College
Office of Student Services
1300 York Avenue, Room C-114, New York, N.Y. 10065
registrar@med.cornell.edu
DO NOT FAX THIS FORM