TRANSFER RESIDENT EVALUATION SUMMARY

TO BE COMPLETED BY CURRENT PROGRAM DIRECTOR

INSTITUTION: _____

PROGRAM: _____

ACGME ACCREDITED: ☐ YES ☐ NO

RESIDENT NAME: _____ _____
FIRST MIDDLE LAST CREDENTIAL

DOB: _____/_____/_____

DATES COVERED BY THIS EVALUATION: FROM: _____ TO: _____

LEVEL(S) OF TRAINING DURING THIS TIME PERIOD:

PGY	START DATE	END DATE

FOR **ACGME ACCREDITED PROGRAMS**:

FINAL REPORTED MILESTONE EVALUATION ATTACHED: ☐

FOR **NON-ACGME ACCREDITED PROGRAMS**, THIS TRAINEE HAS BEEN EVALUATED AS FOLLOWS:

CORE COMPETENCY	EXCEPTIONAL	ACCEPTABLE	UNACCEPTABLE
PATIENT CARE - CLINICAL JUDGMENT			
PATIENT CARE – CLINICAL SKILLS			
MEDICAL KNOWLEDGE			
PROFESSIONALISM – ETHICS			
PROFESSIONALISM – RELIABILITY/DEPENDABILITY			
PROFESSIONALISM - HUMANISTIC SKILLS			
INTERPERSONAL SKILLS AND COMMUNICATION WITH PATIENTS			
INTERPERSONAL SKILLS AND COMMUNICATION WITH MEMBERS OF THE HEALTH CARE TEAM			
PRACTICE BASED LEARNING – EVIDENCE BASED PRACTICE			
SYSTEMS-BASED PRACTICE – RESOURCE UTILIZATION			

	NUMBER OF ATTEMPTS	PASSING SCORE
USMLE 1 ☐ COMLEX 1 ☐		
USMLE 2 ☐ COMLEX 2 ☐		
USMLE 3 ☐ COMLEX 3 ☐		

TO YOUR KNOWLEDGE THE ABOVE INDIVIDUAL:

A) SUBJECT TO ACADEMIC PROBATION? ☐ YES ☐ NO

B) SUBJECT TO DISCIPLINARY ACTION BY TRAINING INSTITUTION OR AFFILIATES? ☐ YES ☐ NO

C) SUBJECT TO DISCIPLINARY ACTION BY THE STATE LICENSURE BOARD? ☐ YES ☐ NO

PLEASE DESCRIBE ALL AFFIRMATIVE ANSWERS (YES) FOR ANY QUESTION ABOVE IN DETAIL BELOW. APPEND ADDITIONAL DOCUMENTATION AS APPROPRIATE.

COMMENTS

Program Director Signature _____ Date_____

Print Name_____ Specialty _____