TEXAS HIGHER EDUCATION COORDINATING BOARD

FAMILY PRACTICE RESIDENCY PROGRAM
RURAL ROTATION

Resident's and Residency Program Director's
Evaluation of Rural Rotation

Directions: **The Resident's and Residency Program Director's Evaluation of the Rural Rotation must be completed by the Resident and the Residency Program Director.**

The Family Practice Resident must complete Sections I through IV.

The Family Practice Residency Program Director must complete Section V and the Grant Request Form.

The Grant Request will not be processed and state funding will not be provided until the evaluation and all required paperwork is returned and reviewed for accuracy and completeness. Due to reduced availability of rural rotation funds, funding of Rural Rotations is based first on a time limited allotment of slots for residency programs, and then on a first-come basis.

After the evaluation form has been completed:

1) The Residency Program Director must return the original completed evaluation and Grant Request form to:

Stacey Silverman, Program Director
Texas Higher Education Coordinating Board
Division of Universities and Health-Related Institutions
P.O. Box 12788
Austin, TX 78711

2) The Residency Program Director must provide a copy of the completed evaluation to the Rural Rotation Supervisor.

FAMILY PRACTICE RESIDENCY PROGRAM
RURAL ROTATION

Resident's and Residency Program Director's Evaluation of Rotation

Name of Resident _____ **Date**_____

Rural Rotation Supervisor_____

Residency Director and Program_____

Directions: After the rotation, the Family Practice Resident must complete the evaluation and meet with the supervisor to discuss the comments. The Resident must return the completed evaluation form to the Residency Program Director. The Program Director must provide additional comments and forward the evaluation to the Texas Higher Education Coordinating Board.

I. Does your supervisor employ:

	Yes	No		Yes	No
1. Receptionist	☐	☐	8. Lab technician	☐	☐
2. Bookkeeper	☐	☐	9. X-ray technician	☐	☐
3. Office Manager	☐	☐	10. Social Worker	☐	☐
4. Registered Nurse	☐	☐	11. Psychotherapist	☐	☐
5. Physician Assistant	☐	☐	12. Dietitian	☐	☐
6. Nurse Practitioner	☐	☐	13. Pharmacist	☐	☐
7. Nursing Assistant	☐	☐	14. Other _____		

II. Estimate the time spent in the following clinical settings:

	Average hours per day	Days per week
Physician's office	1. _____	2. _____
Hospital (inpatient)	3. _____	4. _____
Hospital (emergency room)	5. _____	6. _____
House calls	7. _____	8. _____
Nursing homes	9. _____	10. _____
Other _____	11. _____	12. _____

III. During this rotation, I directly: (Check appropriate column for each item.)

		Frequently	Occasionally	Infrequently	Never	N/A
1.	Performed health maintenance examinations.	☐	☐	☐	☐	☐
2.	Participated in preventive medicine/ immunizations.	☐	☐	☐	☐	☐
3.	Utilized basic problem-oriented approach when completing clinical records.	☐	☐	☐	☐	☐
4.	Provided patient counseling.	☐	☐	☐	☐	☐
5.	Provided patient education.	☐	☐	☐	☐	☐
6.	Sutured lacerations.	☐	☐	☐	☐	☐
7.	Applied casts.	☐	☐	☐	☐	☐
8.	Provided prenatal care.	☐	☐	☐	☐	☐
9.	Participated in obstetrical deliveries.	☐	☐	☐	☐	☐
10.	Assisted in operating room.	☐	☐	☐	☐	☐
11.	Performed well-baby examinations.	☐	☐	☐	☐	☐
12.	Performed Pap smears.	☐	☐	☐	☐	☐
13.	Participated in nursing home care.	☐	☐	☐	☐	☐
14.	Interpreted x-rays (basic findings).	☐	☐	☐	☐	☐
15.	Interpreted EKGs (basic findings).	☐	☐	☐	☐	☐
16.	Performed tonometry testing.	☐	☐	☐	☐	☐
17.	Participated in arranging for a patient referral/consultation.	☐	☐	☐	☐	☐
18.	Participated in continuing medical education conferences.	☐	☐	☐	☐	☐
19.	Participated in laparoscopy.	☐	☐	☐	☐	☐
20.	Participated in colposcopy.	☐	☐	☐	☐	☐
21.	Participated in flexible sigmoidoscopy.	☐	☐	☐	☐	☐
22.	Other: _____	☐	☐	☐	☐	☐
	_____	☐	☐	☐	☐	☐

IV. General Evaluation of this Rotation:

1. Overall this rotation was beneficial to my education as a physician. (Check one)

   Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

2. What do you consider to be the major strengths and weaknesses of this rotation?

   Strengths:

   Weaknesses:

3. What changes would you recommend to improve the rotation?

4. As a result of my Rural Rotation experience, my interest in considering practice in a similar community has:

   Increased Significantly ☐ Been Reinforced ☐ Remained Unchanged ☐ Decreased ☐

5. Based on your Rural Rotation experience, would you recommend to your fellow residents that they also complete a Family Practice Rural Rotation?

   Yes ☐ No ☐

6. Comments (optional)

Resident's Signature **Supervisor's Signature**

Date **Date**

V. Residency Program Director's Comments on Educational Value of Rotation.

1. Apparent strengths and weaknesses of this rotation:

   Strengths:

   Weaknesses:

2. Suggestions for improvement of this rotation:

3. Our program will utilize this site for future family practice rural rotations.

   Yes☐ No☐

4. Other comments:

Program Director's Signature **Date**