

SEMI-ANNUAL RESIDENT REVIEW AND SELF-EVALUATION

Resident: _____

Date: _____

1. Self-Assessment and Monitoring:

1.1 How do you feel your progress in your residency education has been thus far? Any specific strengths or concerns?

1.2 Have you reviewed your *New Innovations* evaluations?

1.3 Have you had any personal changes since your last review? (marriage, divorce, change in career goals, children, health issues, etc.)

1.4 Are you accomplishing the goals and objectives/plan from your last performance review? (not applicable if this is first review as an intern) If not, can you identify the barrier that is preventing progress?

1.5 What is the status of your research requirement?

1.6 Who is your mentor? Have you met with him/her as often as you feel necessary?

2. Program Feedback

2.1 Please give us feedback on the residency program. Is there anything the program should be doing to help your professional development?

2.2 If you would like to discuss any personal stressor, please bring this up at your semi-annual evaluation. This could include discussing specific faculty, rotations, personalities, financial stress, etc.

2.3 What lectures/presentations/conference presentations or posters have you given this year: topic and type (M&M, Friday resident conference, etc.)

3. Professionalism/Administrative Duties

3.1 Administrative Duties: Are you up to date with your:

ACGME Procedure Log Yes No

Evaluations of Faculty Yes No

Evaluations of Residents Yes No

Evaluations of Rotations Yes No

Medical Records Yes No

3.2 Conference attendance: (to be filled in by the coordinator)

Grand Rounds _____

Residents School _____

3.3 Have you observed any significant lapses of professionalism in residents or attendings? Were they addressed?

3.4 Do you have concerns about any of your fellow residents?

4. Fatigue and Stress

4.1. How often do you use alcohol?

0-2 times/week 3-4 times/week > 4 times/week

4.2. Are you using prescription or non-prescription drugs to:

a. Get to sleep? Yes No

b. Stay awake? Yes No

If yes, please describe how frequently medication(s) is being used.

0-2 times/week 3-4 times/week > 4 times/week

4.3. These questions pertain to fatigue:

a. Have you ever fallen asleep at the wheel? Yes No

b. Any accidents or near accidents? Yes No

4.4. Do you think residency has had an adverse impact on your relationships; spouse, children, friends?

Yes No

If yes, with whom: _____

Are you able to identify a plan of action to improve the situation?

4.5 Have you had any duty hour problems since the last review?

Yes No

5. Developing Your Goals and Objectives

5.1 What are your professional goals?

5.2 Please list 2-3 goals/objectives that you would like to achieve in residency in the next six months.

SEMI-ANNUAL REFLECTION AND REVIEW:

RESIDENCY EVALUATION

Resident: _____ **Date:** _____

Mentor: _____ (not selected/present/not present)

1. General Progress in the Residency:

2. Milestone Review:

Specific Issues:

3. **Statistics:**
4. **Primary Care Chart Review:**
5. **Patient Safety/QA Project::**
6. **Research:**
7. **CREOG Score:**
8. **USMLE Step 3**
9. **NRP Certification:**
10. **Pharmacy CME:**
11. **Summary:**

Resident Signature

Faculty Signature

Program Director Signature