

ASSESSMENT/FEEDBACK BY CLINICAL SUPERVISORS

(HIGHER TRAINING)

(revised on 13 March 2015)

This form is designed to help vocational trainees identify their areas of clinical strengths and weaknesses so that specific further training areas can be explored. Frank and constructive feedback from you is essential for this aim. If you have insufficient information to answer a question, please indicate this.

***Please make a copy of the completed form for your records.**

***Please submit the report at least once a year (or at the end of training in each training center whichever is shorter)**

Trainee Doctor _____ Supervisor _____ (Block letter please)

Practicing address _____ Period from _____ to _____

PLEASE RATE THE TRAINEE'S PERFORMANCE (0=very poor, 5=excellent) in the following areas:-

1. Ability of full independent practice in family medicine

0 5

Comments : _____

2. Provision of cost-effective health services to the community

0 5

Comments : _____

3. Ability of handling difficult problems encountered in family medicine practice

0 5

Comments : _____

4. Knowledge and skills in working with families

0 5

Comments : _____

5. Knowledge and skills in handling the care of population with special needs e.g. the elderly, women and the chronically ill in the community

0 5

Comments : _____

6. Attitude of self-directed learning

0

--	--	--	--	--	--

 5

Comments : _____

7. Knowledge and skills of critical appraisal of new information

0

--	--	--	--	--	--

 5

Comments : _____

8. Knowledge, skills and interest in academic family medicine including education, training and research

0

--	--	--	--	--	--

 5

Comments : _____

9. Skills of conducting clinical audit / research

0

--	--	--	--	--	--

 5

Comments : _____

GENERAL COMMENTS:

Please comment on the doctor's progress during the term - the extent to which the doctor's training objectives have been fulfilled. Include any additional comments that might help this doctor become an independent family physician.

RECOMMENDATION:

I * *recommend* / *do not recommend* to the Board of Vocational Training and Standards certifying this trainee for completion of *1year / 2year of Higher Training* during the specified period.

Comments (Obligatory if not recommend) :



Signed and official chop _____

Date : _____

Once complete please return it to *H.K.C.F.P. at Room 803-4, 8/F, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong.*

** Delete as appropriate*