PROGRAM DIRECTOR RECOMMENDATION FORM

This form must be completed by the applicant's previous program director(s) and/or current program director, to provide an appraisal of the applicant's performance which will be used in the selection for further GME training.

1. APPLICANT'S NAME	2. Last 4 SSN	3. SPECIALTY CHOICE
Last: First, MI:		

4. PROGRAM DIRECTOR'S NAME/PHONE NUMBER	5. TRAINING PROGRAM (Circle accreditation status)
Last, First MI Phone #	**SPECIALTY:**

6. LEVEL OF TRAINING BEING EVALUATED

☐ INTERN (90 Days) ☐ INTERN (Year Only) ☐ RESIDENCY ☐ FELLOWSHIP

7. DATES OF TRAINING EVALUATED	8. LOCATION OF TRAINING
UNTIL	

9. COMPARE THIS INDIVIDUAL'S PERFORMANCE TO OTHER TRAINEES IN THE PROGRAM

Top 25%	Middle 50%	Bottom 25%
☐	☐	☐
# trainees in peer group in each category		

10. CORE COMPETENCIES (scores 2 or less in any competency area must be addressed in box 12)

Competency Rating	(inferior) 1	2	(average) 3	4	(superior) 5
Patient Care:	☐	☐	☐	☐	☐
Medical Knowledge:	☐	☐	☐	☐	☐
Practice-based Learning and Improvement:	☐	☐	☐	☐	☐
Interpersonal and Communication Skills:	☐	☐	☐	☐	☐
Professionalism:	☐	☐	☐	☐	☐
Systems-based Practice:	☐	☐	☐	☐	☐

11. WAS THE TRAINEE EVER ON ACADEMIC PROBATION/EXTENTION? ☐ Yes ☐ No

12. Provide specific comments on this individual's performance including any significant problems noted during training or reservations about qualification for further training.

13. Based upon my assessment of this individual's performance,

☐ I highly recommend her/him for further GME
☐ I recommend her/him for further GME
☐ I do not recommend her/him for further GME

14. SIGNATURE OF PROGRAM DIRECTOR	15. DATE