Residency/Fellowship Training Summative Evaluation

Resident/Fellow Name: _______________________________

Training Program: _______________________________
   University of Colorado School of Medicine

Period of Training: _______________________________
   July 1, 20    to June 30, 20___

This is to verify that ______________________, M.D. has successfully completed the Name of Program at the University of Colorado School of Medicine.

Summary of Previous Training (if applicable)
Dr. ______________________ completed residency training with the Name of Program from Date to Date.
Dr. ______________________ completed fellowship training with the Name of Program from Date to Date.

Dr. ______________________ successfully completed our training program on June 30, 20__. (If applicable)
Furthermore, Dr. ______________ served as Chief Resident from Date through Date.

During the course of her training, Dr. ______________ progressively gained proficiency in all areas of clinical Specialty Name. Her skills as a clinician and her surgical aptitude (insert as relevant to specialty) steadily advanced during the course of her training. Dr. ______________ achieved ongoing improvement in the six ACGME General Competencies.

The following is derived from a composite of multiple evaluations by supervisors in this resident’s/fellow’s rotations and experiences during his or her residency/fellowship training. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies, which define the essential components of clinical competence.

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<thead>
<tr>
<th>Medical Knowledge</th>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
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<tr>
<td>Patient Care</td>
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<td>Professionalism</td>
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<td>Communication and Interpersonal Skills</td>
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<td>Practice Based Learning</td>
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<td>Systems Based Practice</td>
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Resident/fellow performance during the final period of training was unsatisfactory/satisfactory in all evaluation sub-categories and on all evaluations. All faculty evaluations during the final year judged him/her competent to complete the name of residency/fellowship program.

In summary, I verify that ______________, M.D. has demonstrated sufficient competence to enter practice without direct supervision in the specialty of ______________________.

______________________________, MD                      ______________
Program Director, __________________________
University of Colorado School of Medicine