

Performance Rating by Preceptor: Family Centered Care Didactic Session

Resident's Name: _____

Preceptor's Name: _____

Date of Session: _____

The Resident:

1. Demonstrated appropriate professional behavior. Yes No
2. Actively listened. Yes No
3. Avoided the use of jargon or medical terms, or explained them. Yes No
4. Generally participated in the discussion. Yes No
5. Asked appropriate questions. Yes No
6. Did the resident arrive/depart at the scheduled time? If no, please explain. Yes No

The Session:

7. Was there more than one resident? If yes, how many? Yes No
8. If there was more than one resident, did this enhance the session? Please explain. Yes No
9. Was the resident post-call? Yes No
10. Was a person representing the family perspective present? If yes, please list who, along with any other staff present. Yes No

Please return this form to:
Physicians Training Project Coordinator
University of Connecticut
A. J. Papanikou Center for Excellence
in Developmental Disabilities
263 Farmington Ave., MC 6222
Farmington, CT 06030
Fax: (860) 679-1571

11. Did the resident make suggestions to enhance future didactic sessions? If yes, please list. Yes No

12. Were there any difficulties with the sessions? Yes No

13. Did you have any outstanding experiences with this session? Yes No

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