

Preceptor Evaluation of 2nd-Year Student

Student: _____	Mentor: _____
	Date of Review: _____

A. Strengths and Challenges	
<input type="checkbox"/> Professional strengths (PE/Hx skills, Presenting skills, note skills, dress/poise, interactions w/ staff, preparedness, pt interactions, promptness)	
<input type="checkbox"/> Personal strengths (things that the student stands out or excels at; feedback from patients about student)	
<input type="checkbox"/> Challenges (areas for improvement, disappointments)	
<input type="checkbox"/> Recommendations for addressing challenges	
OMT In Clinic	
<input type="checkbox"/> Did the student find opportunities to apply their OMT Skills? How did that go?	

Preceptor Signature _____ Date _____

Additional Preceptors:

Preceptor _____ Date _____ - _____

Rotation Type _____ Hours _____

Preceptor _____ Date _____ - _____

Rotation Type _____ Hours _____

Preceptor _____ Date _____ - _____

Rotation Type _____ Hours _____