



program unit
Evaluation form

Student Name:..... ID. No:.....

College of Dental Medicine

Clinical Performance	Infection control	.../5
	Scientific knowledge	.../15
	Clinical Skills	.../15
	Observation time	.../5
	Patient Care	.../5
	General Safety	.../5

Continues Education	Presentation (case or Topic)/10
	Conference/workshop/Journal club/10

Attendance/ Professional conduct/ Behavior	Student Absences (No. of days)	.../10
	Total of late arrival hrs.....Min (per month)	.../5
	Conduct/5
	Appearance/5
	Following the rules/5

	Needs Improvement	Good	Very Good	Excellent
Fail	73 74 75 76 77 78 79	80 81 82 83 84 85 86	87 88 89 90 91 92	93 94 95 96 97 98 99 100

Clinical Supervisor Comments:.....
.....

Clinical Supervisor Name: Signature:

*The evaluation must be mailed in official, sealed envelope.