POST-GRADUATE TRAINING PERFORMANCE ASSESSMENT
(NAVY NADDS/FAP PARTICIPANTS)
MID-YEAR REVIEW FROM JANUARY TO JUNE

Today's Date: _____

Trainee Name: _____
FIRST MI LAST

Name of Institution: __ _____

Program: _____ Research Year Dates (if applicable):_____
Specialty/Subspecialty

Current Program PGY: _____ Year (check one): ☐ Intern ☐ Resident ☐ Fellow

1. Trainee performance:

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:	☐	☐	☐	☐	☐
Overall Evaluation:	☐	☐	☐	☐	☐

2. Has trainee passed Step III of USMLE or Level 3 of COMLEX? Yes_____ No_____

3. Does the trainee have a valid, unrestricted state medical license? Yes_____ No____

4. Will trainee successfully complete curriculum requirements sufficient to be advanced to the next Program Year? Yes_____ No_____

5. Is the trainee on probation? Yes_____ No_____

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6. Projected Graduation Date: ___ _____
(MM/DY/YYYY)

7. Please comment on any competency performance ratings less than 3:

_____

_____

_____

_____

_____

8. Please comment on any notable accomplishments and/or provide other comments:

_____

_____

_____

_____

_____

Has this evaluation been discussed with trainee? Yes_____ No_____ If yes, date:_____

_____ _____

Program Director's Name (Print) **Program Director's Signature** **Date**

Program Director's e-mail: _____

PLEASE SCAN AND SEND COMPLETED FORM TO
USN.OHSTUDENT@MAIL.MIL