

ANGELO STATE UNIVERSITY
College of Nursing and Allied Health
Department of Physical Therapy

Clinical Practicum Mid-term Site Visit Evaluation Form

Date of Visit _____ **Phone** _____ **Site** _____

Student _____

Clinical Practicum I II III (Circle one) Dates of Practicum _____

Facility _____ Type of Practice _____

Clinical Instructor(s) _____

CCCE _____

Student Schedule _____

Days Absent _____ Days Made Up _____

MID-TERM EVALUATION

Completed mid-term evaluation available for review

Student Evaluation Yes ___ No ___ Clinical Instructor Evaluation Yes ___ No ___

If no, please review evaluations with student and clinical instructor/CCCE verbally.

COMMENTS

Student Comments: [Focus on orientation, patient load (types, amount), special experiences, level of supervision/feedback]

Clinical Instructor/facility strengths:

Clinical Instructor/facility weaknesses:

Other comments: (Does the CI understand our systems approach? Have any difficulties arisen? Level of didactic preparation)

Clinical Instructor Comments: (Focus on professional behavior/attitude, communication, documentation, problem solving, selection of evaluation procedures, performance, implementation of solution)

Student strengths:

Student weaknesses:

Other Comments: (inservice, management skills)

ACCE/Faculty Comments:

Site Visitor Signature _____ Date _____