PHILIPPINE BOARD OF ORTHOPAEDICS, INC.

PEER ASSESSMENT TOOL

ASSESSMENT AND FEEDBACK DURING TRAINING

Form **AT-01**

Resident's Name ▶ _____

Institution ▶ _____

Year Level ▶ _____ Date of Assessment ▶ _____

How do you rate this Resident in their:	**Standard:** The assessment be judged against the standard expected at completion of this level of training. Levels of training are defined by respective training programs.						
	Below expectations		Borderline	Meets expectations	Above expectations		U/C[1]
	1	**2**	**3**	**4**	**5**	**6**	
Good Clinical Care							
1. Ability to diagnose patient problems							
2. Ability to formulate appropriate management plans							
3. Awareness of own limitations.							
4. Ability to respond to psychosocial aspects of illness.							
5. Appropriate utilization of resources e.g ordering investigations.							
Maintaining good medical practice							
6. Ability to manage time effectively priorities.							
7. Technical skills (appropriate to Current practice).							
Teaching and Training, Appraising and Assessing							
8. Willingness and effectiveness when Teaching / Training colleagues.							
Relationship with Patients							
9. Communication with patients							
10. Communication with careers and/or family							
11. Respect for patients and their rights To confidentiality							
Working with colleagues							
12. Verbal communication with Colleagues.							
13. Written communication with Colleagues							
14. Ability to recognize and value the Contributions of others.							
15. Accessibility / Reliability							
16. Overall, how do you rate this doctor compared to a doctor ready to complete this level of Training?							

[1] Please mark this if you have not observed the behavior and therefore feel unable to comment

Anything especially good?	Please describe any behavior that has raised concerns or should be a particular focus for development. Include an explanation of any rating below "Meets expectations":

Do you have any concerns about this doctor's probity or health? ☐ YES ☐ NO
If yes, please state your concerns.

Environment observed
(please choose one answer only)

- ☐ Inpatients
- ☐ Outpatients
- ☐ Both In and Out-patients
- ☐ Emergency Department
- ☐ Intensive Care
- ☐ Operating Theatre
- ☐ Others (please specify)

Your position:

- ☐ Consultant, Dept of Ortho
- ☐ Co-resident, Ortho
- ☐ Co-resident, Other dept
- ☐ Nurse
- ☐ Allied Health Professional
- ☐ Others (please specify)

Thank you for your participation in this assessment. This feedback is valuable to our training program.

Evaluator's Name and Signature ▶	
Date ▶	