Name of Policy: **GME: Resident Final Evaluation Letter** **Policy Number**: **3364-86-024-00** **Approving Officer**: **Dean, College of Medicine and Life Sciences** **Responsible Agent**: **Director, Graduate Medical Education** **Scope**: **UT College of Medicine Residents**	**Revised date: 05/07/19** **Original Effective date**: **06/03/08**

____	New policy proposal	**X**	Minor/technical revision of existing policy
____	Major revision of existing policy	____	Reaffirmation of existing policy

POLICY

Program Directors must provide a final evaluation for each resident upon completion of the program. The evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident.

PURPOSE

To document the resident's performance during the final period of education and provide a final evaluation of a resident's performance while in a Graduate Medical Education Program at The University of Toledo (UT). This document will provide information for future credentialing of the resident after leaving The University of Toledo.

PROCEDURE

1. During the final month of a resident's training at UT, the resident's program director will complete a final evaluation of the resident's performance.

2. The final evaluation must address the resident's level of achievement in satisfying the ACGME six general competencies. The specialty specific milestones and, when appropriate, case logs must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.

3. The final evaluation must contain accurate evaluations of the resident's knowledge, skills and behaviors, and must document the resident's performance during the final period of education, and verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

4. The resident's list of procedures for which the resident has met the requirements for independent practice should be attached to the final evaluation.

5. An original copy of the final evaluation should be given to:
    a. The resident
    b. The resident's permanent record in the residency program.
    c. The Graduate Medical Education resident's credentialing file, via New Innovations.

An example of a final evaluation is attached as Appendix A.

Approved by: */s/ Lori Schuh, M.D.* Chair, Graduate Medical Education Committee *Christopher Cooper, M.D.* Dean, College of Medicine and Life Sciences Review/Revision Completed by: *Graduate Medical Education Committee*	Policies Superseded by This Policy**:** • *None* Initial effective date: 06/03/08 Review/Revision Date: Reviewed 6/02, Reviewed 6/04, reviewed 6/2/06, Revised 6/3/08, Revised 6/1/10, Reviewed 6/5/12, Revised 6/3/14 (with a 7/1 effective date), Revised 11/4/2014, Revised 7/7/2015, Reviewed 9/5/17, Revised 5/7/19 **Next review date: 5/2021**

Note: The printed copy of this policy may not be the most current version; therefore, please refer to the policy website *(http://utoledo.edu/policies)* for the most current copy.

Appendix A

COLLEGE OF MEDICINE
THE UNIVERSITY OF TOLEDO

Final Evaluation
_____RESIDENCY PROGRAM
CONFIDENTIAL VERIFICATION AND REFERENCE FOR:

NAME:

This confidential document relating to the above resident is provided to you by The University of Toledo _____Residency Program. We submit this document in response to your request for verification of _____Residency training and reference information in lieu of other forms. The original notarized signature of the current program director will verify its authenticity. The contents of this document are provided with the permission of the above-named physician and should not be released to any other party without the consent of that physician.

This evaluation will be part of the resident's permanent record maintained by the institution, and will be accessible for review by the resident in accordance with institutional policy.

I. Verification of Training:

☐ Dr. **NAME** successfully completed _____ residency training at The University of Toledo as follows:
Internship Dates:
Residency Dates:

☐ See Appendix Item I. *[optional statement of any deviation from standard training sequence]*

II. Disciplinary Action:

☐ During the dates of training at this institution, Dr. **NAME** was not subject to any institutional disciplinary action.

☐ See Appendix Item II. *[Description of disciplinary actions. This would **not** normally include Corrective Actions instituted for educational reasons which have been successfully remediated.]*

III. **Professional Liability:** Dr **NAME** was provided professional liability insurance for activity related to residency training, which includes extended reporting (tail) coverage for claims occurring during training but reported after training has concluded.

☐ To the best of our knowledge, Dr. **NAME** was not investigated by any governmental or other legal body and was not the defendant in any malpractice suit during residency training.

☐ See Appendix Item III. *[Description of investigations and malpractice suits]*

IV. **Ability to Practice Medicine:**

☐ To the best of our knowledge, no conditions exist that would impair Dr. **NAME** ability to practice _____.

☐ See Appendix Item IV. *[If this item is checked, explanations will usually deal with conditions covered by the ADA. Consult legal counsel about how to complete in a manner which complies with the ADA.]*

V. **Clinical Privileges/Procedures Requested.**

☐ The education Dr. **NAME** received from our training program was sufficient for the practice of _____. Dr. **NAME** was recommended for the certifying examination administered by the American Board_____.

☐ At the conclusion of Dr. **NAME** _____residency training, he/she was judged capable of performing the following procedures independently:

☐ Arthrocentesis	☐ Lumbar puncture
☐ Paracentesis	☐ Insertion of subclavian central line
☐ Insertion of femoral central line	☐ Insertion of internal jugular central line
☐ Insertion of arterial line	☐ Bone marrow aspiration and biopsy
☐ Punch skin biopsy	☐ Thoracentesis
☐ Other _____	

☐ I am unable to comment on requested clinical privileges/procedures outside the scope of a_____ residency training program.

VI. **Evaluation**:

During the final period of education, Dr **NAME**'s performance in achieving the six general competencies was:

	Unsatisfactory	**Satisfactory**
Medical Knowledge		
Patient Care		
Practice-Based Learning		
Communication/Interpersonal Skills		
Professionalism		
Systems-Based Practice		

The following table is based on the demonstrated performance of Dr. **NAME** during residency training, personal observation by members of the Department of _____, Clinical Competency Committee recommendations milestone evaluations, case logs where applicable, and a composite of multiple evaluations by supervisors.

	Unsatisfactory	Satisfactory	Superior	No Knowledge
Medical Knowledge				
Patient Care				
Clinical Skills/Clinical Competence				
Patient Management Skills				
Technical Skills				
Physician/Patient Relationship				
Practice-Based Learning				
Communication/Interpersonal Skills				
Cooperativeness, Ability to Work with Others				
Ability to Understand and Speak English				
Professionalism				
Sense of Responsibility				
Record Keeping				
System-Based Practice				
Ethical Conduct				
Teaching of Students				

VII. Summary:

☐ Dr. **NAME**'s performance during his/her residency has been both ethical and professional.

☐ Dr. **NAME** has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

☐ **Additional Comments:**

_____
_____
_____

VIII. **Recommendation:**
Based on a composite evaluation by The University of Toledo, Department of___
Education Committee, Dr. **NAME** is recommended to you this 30th day of June, 20__.

_____
Name
Residency Program Director

☐ I have reviewed this evaluation with the program director or designee. I understand that this form will, in most cases, be utilized as the confidential verification and reference form in lieu of other forms when requests for verification of resident training and/or reference are received by the Department of _____.

_____
***NAME**, M.D. [SIGNATURE OF RESIDENT]*

☐ Resident refused to sign.

_____
Residency, Program Director

****

"I attest that the foregoing information supplied is true in every respect"	Date:		Signature: (Residency Program Director)
Notary Public Seal	State of Ohio	United States	Name:
	Subscribed and Sworn Before me on this day:		[Address of Program Director signing]
	Notary Public Signature		
	Notary Public Name (type or printed)		Commission Expires: