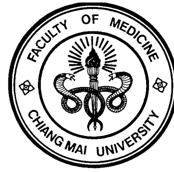
Evaluation Form



SELECTIVE EXPERIENTIAL LEARNING
FACULTY OF MEDICINE, CHIANG MAI UNIVERSITY

Student's name……………………………………………………………………………………

Thai Name…………………………………..Student code…………….…………...

Period of training…………………………………………………………..………………

Institute…………………..……..………Department………………….....………..……

Supervisor's name…………………………………………………………………………

Attendance: full ( ) Absence……….day(s)
Reason…………………………………..……………………

Please tick in the appropriate box provided.

Assessment	Excellent (4)	Good (3)	Fair (2)	Poor (1)	Remarks
Knowledge					
Clinical skills					
Communication skill					
Professional behavior					
Commitment Responsibility & interest in clinical clerkship					

Overall ( ) Satisfactory ( ) Unsatisfactory

Suggestions……………………………………………………...……………………

……………………………………………………………..…………………………

Please return completed form to:
Student Affairs Office
Faculty of Medicine
Chiang Mai University
110 Intawaroros Road
Tambol Sriphum Amphoe Muang
Chiang Mai 50200 Thailand

Signature……………………………
Date of signature……………………
Email………………………………..
(seal)