



Regional Academic Affairs

TITLE: Final Resident/Fellow Evaluation

POLICY NUMBER: S-12

DEPARTMENT: Graduate Medical Education

Effective Date: 07/01

Revised: 08/24

Reviewed: 08/24

Date of next Review: 08/26

POLICY:

Program Directors must write a Final Evaluation to be placed in the resident's/fellow's ("resident") permanent record.

PURPOSE:

To provide a final summary of a resident's performance while in a Mercy Health - St. Vincent Medical Center (MHSVMC) Graduate Medical Education Program. This document will provide information for future credentialing of the resident after leaving Mercy St. Vincent Medical Center.

PROCEDURE:

1. During the final month of a resident's training at MHSVMC, the resident's program director with input from the Clinical Competency Committee will complete the "Final Evaluation and Confidential Verification/Reference Form" (SECVF) as a summary of the resident's performance. This letter should be a stand-alone document for use in credentialing/verification purposes.
2. The resident's SECVF must contain accurate evaluations of the resident's knowledge, skills and professional attitude. This would include the overall resident's attainment of competency in the six ACGME competencies, CPME, or applicable accreditation requirements. This evaluation must verify that the resident has demonstrated sufficient competence to enter autonomous practice.
3. At a minimum, the Final Evaluation/SECVF must include:
 - a. Assessment of the core ACGME/CPME/ or applicable accreditation competencies for the overall program.
 - b. The resident's list of procedures for which the program is credentialing them for autonomous practice.
 - c. Contain the following language "has demonstrated sufficient competence to enter autonomous practice". Transitional Year graduate should contain the language "the resident has demonstrated sufficient competence and has successfully completed the transitional year residency".
 - d. The Program Directors for ACGME programs must use the template (Appendix A) Additional items can be added if the program so chooses. This form may be modified for use in the Podiatric Surgery Residency or non-ACGME programs accredited if so desired.

4. The resident's list of procedures for which the resident has demonstrated sufficient competence to perform should be attached to this Final Evaluation form.

A signed original Summative Evaluation and Confidential/Reference Form should be given to the Resident. A copy must be maintained in the resident's file in the program office. This evaluation will be accessible for review by the resident in accordance with institutional policy.

Approved by:



Randall Schlievert, MD
VP, Academic Affairs, Mercy Health - Toledo
DIO, Mercy Health - St. Vincent Medical Center



[Name of Residency/Fellowship]
Mercy Health – St. Vincent Medical Center, LLC
Final Evaluation and Confidential Verification/Reference Form

Name: _____

Dates of Training: _____ to _____
Mo/Yr. Mo/Yr.

This final evaluation pertaining to the above resident is provided to you by the [Name of Residency/Fellowship] Program at Mercy St. Vincent Medical Center. This letter serves as both a Final Evaluation of the resident’s overall performance and attainment of competency during residency. In addition, this letter may serve as verification of residency training. The signature of the resident indicates that permission to release this form in response to training verification requests has been granted by the above program. **Finally, this letter indicates that the resident has demonstrated sufficient competence to enter autonomous practice (unless the resident is graduating from a transitional year program, whereby this letter indicates the resident has demonstrated sufficient competence and has successfully completed the transitional year residency).**

This Final Evaluation is a composite of the resident’s total performance while in their training program.

I. Attainment of Competencies During Overall Educational Training:

Competency	Satisfactory	Unsatisfactory	No Information
Patient Care			
Medical Knowledge			
Professionalism			
Communication and Interpersonal Skills			
Practice Based Learning			
Systems Based Practice			
Resident as Teacher			

II. Disciplinary Action and Evaluation of Professionalism and Ethics:

During the dates of training, Dr. _____ was not subject to disciplinary action resulting in probation.

Disciplinary action exists. Please see attachment A.

III. Professional Liability:

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

See attachment B.

IV. Ability to Enter Practice of Medicine:

To the best of our knowledge, no conditions exist that would impair Dr. _____ ability to practice medicine *[if a transitional year resident, this checkmark indicates, to the best of our knowledge, no conditions exist that would impair Dr. _____ ability to enter the next educational training program].*

See appendix C. If checked, please consult legal department on how to complete in a manner which complies with the ADA.

V. Clinical Procedures:

Please see attached delineation of clinical procedures that the program has deemed this physician able to competently perform independently. If there are procedures requested that fall outside the scope of the training program, please see comments below:

VII: Concluding Evaluation and Comments:

I have reviewed the overall performance of this resident and verify that this resident has completed all requirements set forth by the ACGME, **[insert program specialty]** RRC, CPME or applicable accrediting body for and the Policies and Procedures of the **[Name of Residency/Fellowship]**, and has demonstrated sufficient competence in Medical Knowledge, Patient Care, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice. Having met the competency training requirements, the signature of the program director below indicates that:

Dr. _____ was deemed to have demonstrated sufficient competence to enter autonomous practice. *[for transitional year graduating residents, use “the signature of the program director indicates Dr. _____ has demonstrated sufficient competence and has successfully completed the transitional year residency”].*

[Insert Program Director Name]

Date

Resident/Intern

Date

Program Director

[Name of Residency/Fellowship]

Mercy Health – St. Vincent Medical Center, LLC

Resident/intern refused to sign

