


<b>Name of Policy:</b> Resident Summative Evaluation Letter <b>Policy Number:</b> 3364-86-024-00 <b>Approving Officer:</b> Dean, College of Medicine and Life Sciences <b>Responsible Agent:</b> Director, Graduate Medical Education <b>Scope:</b> UT College of Medicine Residents	 <b>Effective date:</b> 09/05/17
<input type="checkbox"/> New policy proposal	<input type="checkbox"/> Minor/technical revision of existing policy
<input type="checkbox"/> Major revision of existing policy	<input checked="" type="checkbox"/> Reaffirmation of existing policy

POLICY

Program Directors must provide a summative 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


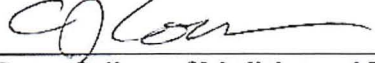
To document the resident's performance during the final period of education and provide a summative evaluation of a resident's performance while in a Graduate Medical Education Program at The University of Toledo (UT). This document will provide information for future credentialing of the resident after 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 summative evaluation of the resident's performance.
2. The summative evaluation must address the resident's level of achievement in satisfying the ACGME six general competencies and achievement of milestones. The specialty specific milestones must be used as one of the tools to ensure residents are able to practice core professional activities upon completion of the program.
3. The summative evaluation must contain accurate evaluations of the resident's knowledge, skills and professional attitudes, and must document the resident's performance during the final period of education, and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

4. The resident's list of procedures for which the resident has met the requirements for independent practice should be attached to the summative evaluation.
5. An original copy of the summative 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 Summative evaluation is attached as Appendix A.

<p>Approved by:</p> <p>          _____          Chair, Graduate Medical Education Committee</p> <p>          _____          Dean, College of Medicine and Life Sciences</p> <p>Review/Revision Completed by:  <i>Graduate Medical Education Committee</i></p>	<p>Policies Superseded by This Policy:</p> <ul style="list-style-type: none"> <li>• <i>None</i></li> </ul> <p>Initial effective date: 06/03/08</p> <p>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</p> <p>Next review date: 9/2019</p>
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**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.



COLLEGE OF MEDICINE  
THE UNIVERSITY OF TOLEDO

Summative Evaluation  
RESIDENCY PROGRAM  
CONFIDENTIAL VERIFICATION AND REFERENCE FOR:

NAME:

This confidential document relating to the above resident 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
  - Paracentesis
  - Insertion of femoral central line
  - Insertion of arterial line
  - Punch skin biopsy
  - Other \_\_\_\_\_
  - Lumbar puncture
  - Insertion of subclavian central line
  - Insertion of internal jugular central line
  - Bone marrow aspiration and biopsy
  - Thoracentesis
- 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
<b>Medical Knowledge</b>		
<b>Patient Care</b>		
<b>Practice-Based Learning</b>		
<b>Communication/Interpersonal Skills</b>		
<b>Professionalism</b>		
<b>Systems-Based Practice</b>		

The following table is based on the demonstrated performance of Dr. NAME during residency training, personal observation by members of the Department of \_\_\_\_\_ Education Committee and a composite of multiple evaluations by supervisors.

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

**VII. Summary:**

- Dr. NAME's performance during his/her residency has been both ethical and professional.
- Dr. NAME has demonstrated sufficient competence to enter practice without direct supervision.
- Additional Comments:**

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**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*

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"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: