



FINAL GRADUATE MEDICAL EDUCATION TRAINING FORM

Specialty: \_\_\_\_\_

First Name

Last Name

(M.D., D.O., etc)

Served in the following capacity:

First Year Medical Resident

Month/Year – Month/Year

Second Year Medical Resident

Third Year Medical Resident

To our knowledge the above individual:

- a) Subject to academic probation?
b) Subject to disciplinary action by Loyola University Medical Center?
c) Subject to disciplinary action by the state licensure board?

Note: Affirmative answers (yes) for any question above must be described in detail below. Additional documentation shall be appended as appropriate.

Four horizontal lines for providing additional documentation.

Summary evaluation of Resident performance:

Table with 3 columns: Exceptional, Acceptable, Unacceptable. Rows include Patient Care - Clinical judgment, Medical Knowledge, Professionalism - ethics, etc.

I hereby verify that the above referenced trainee has successfully completed program? Yes No

I hereby verify that the above referenced trainee has demonstrated sufficient competence to enter practice without direct supervision in the specialty noted above. Yes No

Comments

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Signature \_\_\_\_\_  
Program Director

\_\_\_\_\_ Date

Print Name \_\_\_\_\_  
Program Director

\_\_\_\_\_ Specialty

I hereby authorize and consent to the release by Loyola University Medical Center, the Graduate Medical Education Office and representatives to other training programs, hospitals, their medical staff and their representatives, physician foundations, payors, and to medical associations this final evaluation and any additional necessary information the Loyola University Medical Center, the Graduate Medical Education Office and representatives may have concerning my professional competence, ethics, character and other professional qualifications, as long as such release is done in good faith and without malice, and I hereby release from liability this Loyola University Medical Center, the Graduate Medical Education Office and representatives for so doing.

Signature \_\_\_\_\_  
House Staff Officer

\_\_\_\_\_ Date

Print Name \_\_\_\_\_  
House Staff Officer

\_\_\_\_\_ Specialty

Copy to: Office of Graduate Medical Education