

	Unable to Answer	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
11. Medical records, x-ray, films, and results of diagnostic studies were readily available when needed.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rotation Value

	Not Applicable	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
12. Overall Educational Value of this Clinical Activity.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General Program Satisfaction

	Cannot Evaluate	Unsatisfactory	Marginal	Satisfactory/Meets Expectations	Very Good	Outstanding
	0	1	2	3	4	5
13. Rate your current overall level of satisfaction with the residency program.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rotation Strengths

Describe the strengths of this clinical activity compared to the others you have taken. *

Rotation Weaknesses

Describe the weaknesses of this clinical activity and suggest areas for improvement. *

Confidential Comments, Rotation

This area is for providing positive or negative feedback that you don't feel comfortable giving directly. These comments will NOT go directly to rotation coordinators. They will go to the Program Director and Department Head who

may contact you to discuss your concerns
further. *