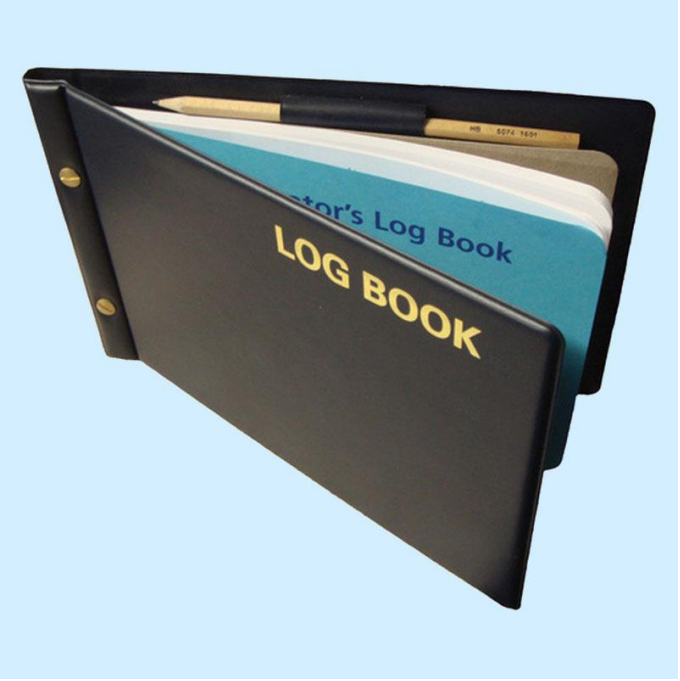
LOG BOOK FOR MD GASTROENTEROLOGY

RAWALPINDI MEDICAL UNIVERSITYRAWALPINDI



PREFACE

The horizons of *Medical Education* are widening & there has been a steady rise of global interest in *Post Graduate Medical Education*, an increased awareness of the necessity for experience in education skills for all healthcare professionals and the need for some formal recognition of postgraduate training in Internal Medicine.

We are seeing a rise in the uptake of places on postgraduate courses in medical education, more frequent issues of medical education journals and the further development of e-journals and other new online resources. There is therefore a need to provide active support in *Post Graduate Medical Education* for a larger, national group of colleagues in all specialties and at all stages of their personal professional development. If we were to formulate a statement of intent to explain the purpose of this log book, we might simply say that our aim is to help clinical colleagues to teach and to help students to learn in a better and advanced way. This book is a state of the art log book with representation of all activities of the MD Internal Medicine program at RMU.A summary of the curriculum is incorporated in the logbook for convenience of supervisors and residents. MD curriculum is based on six Core Competencies of ACGME ***(Accreditation Council for Graduate Medical Education)***including ***Patient Care, Medical Knowledge, System Based Practice, Practice Based Learning, Professionalism, Interpersonal and Communication Skills***. A perfect monitoring system of a training program including monitoring of teaching and learning strategies, assessment and Research Activities cannot be denied so we at RMU have incorporated evaluation by ***Quality Assurance Cell*** and its comments in the logbook in addition to evaluation by ***University Training Monitoring Cell (URTMC)***. Reflection of the supervisor in each and every section of the logbook has been made sure to ensure transparency in the training program. The mission of Rawalpindi Medical University is to improve the health of the communities and we serve through education, biomedical research and health care. As an integral part of this mission, importance of research culture and establishment of a comprehensive research structure and research curriculum for the residents has been formulated and a separate journal for research publications of residents is available.

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CONTRIBUTIONS

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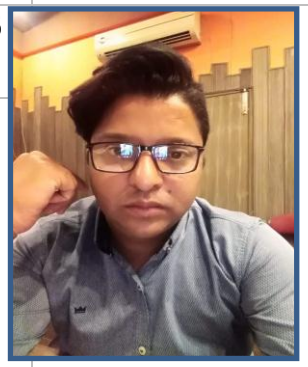
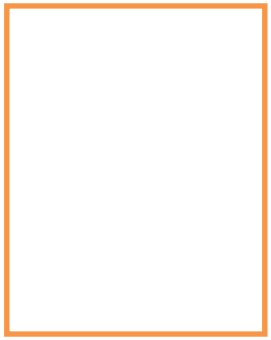
2.		**Dr. Bushra Kharr, MBBS.FCPS** **Ex-Professor of Medicine** **Head Department of Gastroenterology** **Holy Family Hospital Rawalpindi** Guidance regarding technical matters of Log Book of MD Gastroenterology & also Log Book for MD Gastroenterology rotations. Provision of required number of clinical procedures and educational activities for each year separately and rotation of log books of MD gastroenterology and log book MD gastroenterology rotations.	5.		**Dr. Javeria Khan, MBBS,FCPS** **Consultant Gastroenterologist** **Holy family Hospital, RWP** Proof reading, organizing and re assembling of MD gastroenterology Log book and Rotation log book
3.		**Dr. Tanveer Hussain, MBBS, FCPS(MED), FCPS(Gastroenterology)** **Assistant Professor of Gastroenterology** **Holy Family Hospital Rawalpindi** Guidance regarding technical matters of Log Book of MD Gastroenterology & also Log Book for MD Gastroenterology rotations.	6		**MR. JAHANZEB KHAN** **Computer Operator** **Holy Family Hospital, RWP** Proof reading & synthesis of final print version of Log Books of MD Gastroenterology and Rotation Log Book.

ENROLMENT DETAILS



Program of Admission _____

Session _____

Registration / Training Number _____

Name of Candidate _____

Father's Name _____

Date of Birth _____ / _____ / _____ CNIC No. _____

Present Address _____

_____

Permanent Address _____

_____

E-mail Address _____

Cell Phone _____

Date of Start of Training _____

Date of Completion of Training _____

Name of Supervisor _____

Designation of Supervisor _____

Qualification of Supervisor _____

Title of department / Unit _____

INTRODUCTION OF LOGBOOK:

It is a structured book in which certain types of educational activities and patient related information is recorded, usually by hand. Logbooks are used all over the world from undergraduate to postgraduate training, in human, veterinary and dental medicine, nursing schools and pharmacy, either in paper or electronic format .

Logbooks provide a clear setting of learning objectives and give trainees and clinical teachers a quick overview of the requirements of training and an idea of the learning progress. Logbooks are especially useful if different sites are involved in the training to set a (minimum) standard of training. Logbooks assist supervisors and trainees to see at one glance which learning objectives have not yet been accomplished and to set a learning plan. The analysis of logbooks can reveal weak points of training and can evaluate whether trainees have fulfilled the minimum requirements of training.

Logbooks facilitate communication between the trainee and clinical teacher. Logbooks help to structure and standardize learning in clinical settings. In contrast to portfolios, which focus on students' documentation and self-reflection of their learning activities, logbooks set clear learning objectives and help to structure the learning process in clinical settings and to ease communication between trainee and clinical teacher. To implement logbooks in clinical training successfully, logbooks have to be an integrated part of the curriculum and the daily routine on the ward. Continuous measures of quality management are necessary.

Reference

Brauns KS,Narciss E, Schneyinck C, Böhme K, Brüstle P, Holzmann UM, etal. Twelve tips for successfully implementing logbooks in clinical training. Med Teach. 2016 Jun 2; 38(6): 564–569.

INDEX OF LOG:

MINIMUM LOG BOOK ENTERIES PER MONTH IN GENERAL

(This minimum number is being provided for uniformity of the training and convenience for monitoring of the resident's performance by Quality Assurance Cell & University Research Training & Monitoring Cell of RMU but resident is encouraged to show performance above this minimum required number)

Serial No	ENTRY	SUB ENTRY		MINIMUM CASES/TIME DURATION
1	Clinical meetings/Teaching sessions / large group Discussion/Bed Side Teachings	1.Case presentation	1/month	15/month
		2. Topic Presentation	1/month	
		3. Journal Club	1/month	
		4. Mortality & Morbidity Discussions	1/month	
		5. bed side teachings/large group discussion	15 /month	
2	CPC	01/month		
3	Procedure Documentation/DOPS	6-10/month		
4	Indoor Patient Documentation	15/month		
5	Emergency Cases Documentation	50/month during Emergency allocated duties		
6	OPD cases Documentation	50/month during OPD allocated duties		

CLINICAL COMPETENCIES FOR 1ST,2ND, AND 3rdYEAR MD TRAINEES GASTROENTEROLOGY

CLINICAL COMPETENCIES\SKILL\PROCEDURE

The clinical competencies, a specialist must have, are varied and complex. A complete list of the skills necessary for trainees and trainers is given below. The level of competence to be achieved each year is specified according to the key, as follows:

1. Observer status
2. Assistant status
3. Performed under supervision
4. Performed under indirect supervision
5. Performed independently

Note: Levels 4 and 5 for practical purposes are almost synonymous

PROCEDURES	First Year (R1)								
	3Months		6Months		9Months		12Months		Total Cases 1st Year
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	
Pleural Aspiration	4	2	4	2	4	2	4	2	8
Peritoneal Aspiration	4	10	4	10	4	8	5	7	35
Nasogastric Intubation	4,5	10	4,5	10	4,5	5	5	5	30
Urethral catheterization	4,5	2	4,5	2	4,5	1	5	1	6
Recording and reporting ECG	4,5	3	4,5	3	4,5	3	5	3	12
Sigmoidoscopy	-	-	1	20	1,2	15	2,3	15	50
Endotracheal Intubation	4	2	4	2	4	2	4	2	08
Cardio-Pulmonary Resuscitation (CPR)	4	2	4,5	2	4, 5	2	5	2	08
Insertion of CVP lines	4,5	2	4,5	2	5	2	5	2	08
Arterial puncture	4,5	1	4,5	1	5	1	5	1	4
Liver biopsy	2	5	2	5	2	5	2	5	20
Upper G.I. Endoscopy (diagnostic& Therapeutic))	1,2	50	2,3	50	3,4	50	4,5	50	200
Lower G.I. Endoscopy (diagnostic& Therapeutic)	1,2	10	2,3	10	3,4	20	3,4	30	70
Abdominal Ultrasound	1	1	1	1	1	1	2	1	4
CT Scan abdomen/pelvis	1	1	1	3	1	6	1	10	20
MRI Abdomen	1	1	1	3	1	6	1	10	20
MRCP	1	1	1	3	1	6	1	10	20
ERCP	-	-	1	5	1	5	1	10	20
HRM	-		1	5	1	5	1	5	15
Fibro scan	-		1	5	1	5	1	5	15
EUS	-		1	5	1	5	1	5	15

PROCEDURES	2nd Year (R2)								
	3Months		6Months		9Months		12Months		Total Cases 1st Year
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	
Rotations to be incorporated as and when available with the consent of respected supervisor									
Pleural Aspiration	5	2	5	2	5	2	5	2	8
Peritoneal Aspiration	5	5	5	5	5	5	5	5	20
Nasogastric Intubation	5	6	5	4	5	4	5	6	20
Urethral catheterization	5	2	5	2	5	2	5	2	8
Recording and reporting ECG	5	4	5	2	5	2	5	2	10
Sigmoidoscopy	2,3	10	3,4	10	4,5	10	4,5	20	50
Endotracheal Intubation	5	4	5	2	5	2	5	2	10
Cardio-Pulmonary Resuscitation (CPR)	5	4	5	4	5	4	5	3	15
Insertion of CVP lines	5	4	5	4	5	4	5	3	15
Arterial puncture	5	4	5	2	5	2	5	2	10
Liver biopsy	2	5	2,3	5	2,3	5	3	5	20
Upper G.I. Endoscopy (diagnostic & therapeutic)	4,5	50	4,5	50	4,5	50	4,5	50	200
Lower G.I. Endoscopy (diagnostic & therapeutic)	3,4	10	3,4	15	4,5	20	4,5	20	65
Abdominal Ultrasound	1,2	5	1,2	5	1,2	5	1,2	5	20
CT Scan abdomen/pelvis	1,2	5	1,2	5	1,2	5	1,2	5	20
MRI Abdomen	1,2	5	1,2	5	1,2	5	1,2	5	20
MRCP	1,2	3	1,2	3	1,2	7	1,2	9	22
ERCP	1,2	10	1,2	10	1,2	10	1,2	10	40
HRM	1,2	4	1,2	4	1,2	4	1,2	4	16
Fibro scan	1,2	4	1,2	4	2,3	4	2,3	10	22
EUS	1,2	2	1,2	3	1,2	5	1,2	5	15

PROCEDURES	3rd Year(R3)								
	3Months		6Months		9Months		12Months		Total Cases 3rd Year
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	
Pleural Aspiration	5	2	5	2	5	2	5	2	8
Peritoneal Aspiration	5	6	5	6	5	6	5	7	25
Nasogastric Intubation	5	4	5	2	5	2	5	2	10
Urethral catheterization	5	1	3	1	5	1	5	1	4
Recording and reporting ECG	5	5	5	5	5	5	5	5	20
Sigmoidoscopy	4,5	20	5	30	5	30	5	30	110
Endotracheal Intubation	5	1	5	1	5	1	5	1	4
Cardio-Pulmonary Resuscitation (CPR)	5	4	5	2	5	2	5	2	10
Insertion of CVP lines	5	4	5	2	5	2	5	2	10
Arterial puncture	5	4	5	2	5	2	5	2	10
Liver biopsy	3	5	3	5	3,4	5	5	5	20
Upper G.I. Endoscopy (diagnostic & therapeutic)	5	50	5	50	5	50	5	50	200
Lower G.I. Endoscopy (diagnostic & therapeutic)	3,4	10	3,4	10	4,5	20	4/5	30	70
Abdominal Ultrasound	2,3	1	2,3	1	2,3	1	2,3	1	4
CT Scan abdomen	1,2	1	1,2	3	1,2	3	2,3	3	10
MRI Abdomen	1,2	1	1,2	3	1,2	3	2,3	3	10
MRCP	1,2	1	1,2	3	1,2	7	2,3	11	22
ERCP	1	10	2, 3	10	3	10	4,5	10	40
HRM	2,3	5	3	5	3,4	5	5	5	20
Fibro scan	3,4	5	3,4	5	5	5	4,5	5	20
EUS	1	5	1,2	5	1,2	5	1,2	5	20

INTRODUCTION

Curriculum of MD Gastroenterology at Rawalpindi Medical University is an important document that defines the educational goals of Residency Training Program and is intended to clarify the learning objectives for all inpatient and outpatient rotations. Program requirements are based on the ACGME(Accreditation Council for Graduate Medical Education) standards for categorical training in Gastroenterology. Curriculum is based on 6 core competencies. Detail of these competencies is as follows

CORE COMPETENCIES

Details of The Six Core Competencies of Curriculum of MD Internal Medicine

COMPETENCY NO. 1 PATIENT CARE (PC)

- **Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1)**
  - Collects accurate historical data
  - Uses physical exam to confirm history
  - Does not relies exclusively on documentation of others to generate own database or differential diagnosis
  - Consistently acquires accurate and relevant histories from patients
  - Seeks and obtains data from secondary sources when needed
  - Consistently performs accurate and appropriately thorough physical exams
  - Uses collected data to define a patient's central clinical problem(s)
  - Acquires accurate histories from patients in an efficient, prioritized, and hypothesis- driven fashion
  - Performs accurate physical exams that are targeted to the patient's complaints
  - Synthesizes data to generate a prioritized differential diagnosis and problem list
  - Effectively uses history and physical examination skills to minimize the need for furtherdiagnostic testing
  - Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis
  - Identifies subtle or unusual physical exam findings
  - Efficiently utilizes all sources of secondary data to inform differential diagnosis
  - Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing
- **Develops and achieves comprehensive management plan for each patient. (PC2)**
  - Care plans are consistently inappropriate or inaccurate
  - Does not react to situations that require urgent or emergent care
  - Does not seek additional guidance when needed Inconsistently develops an appropriate care plan
  - Inconsistently seeks additional guidance when needed
  - Consistently develops appropriate care plan
  - Recognizes situations requiring urgent or emergent care

- Seeks additional guidance and/or consultation as appropriate
- Appropriately modifies care plans based on patient's clinical course, additional data, and patient preferences
- Recognizes disease presentations that deviate from common patterns and require complex decision- making
- Manages complex acute and chronic diseases
- Role models and teaches complex and patient-centered care
- Develops customized, prioritized care plans for the most complex patients, incorporating diagnostic uncertainty and cost effectiveness principles

- **Manages patients with progressive responsibility and independence. (PC3)**
  - Assume responsibility for patient management decisions
  - Consistently manages simple ambulatory complaints or common chronic diseases
  - Consistently manages patients with straightforward diagnoses in the inpatient setting
  - Unable to manage complex inpatients or patients requiring intensive care
  - Requires indirect supervision to ensure patient safety and quality care
  - Provides appropriate preventive care and chronic disease management in the ambulatory setting
  - Provides comprehensive care for single or multiple diagnoses in the inpatient setting
  - Under supervision, provides appropriate care in the intensive care unit Initiates management plan for urgent or emergent care
  - Independently supervise care provided by junior members of the physician-led team
  - Independently manages patients across inpatient and ambulatory clinical settings who have a broad spectrum of clinical disorders including undifferentiated syndromes
  - Seeks additional guidance and/or consultation as appropriate
  - Appropriately manages situations requiring urgent or emergent care
  - Effectively supervises the management decisions of the team
  - Manages unusual, rare, or complex disorders
- **Skill in performing procedures. (PC4)**
  - Does not attempts to perform procedures without sufficient technical skill or supervision
  - Willing to perform procedures when qualified and necessary for patient care
  - Possesses basic technical skill for the completion of some common procedures
  - Possesses technical skill and has successfully performed all procedures required for certification
  - Maximizes patient comfort and safety when performing procedures
  - Seeks to independently perform additional procedures (beyond those required for certification) that are anticipated for future practice
  - Teaches and supervises the performance of procedures by junior members of the team
- **Requests and provides consultative care. (PC5)**
  - Is responsive to questions or concerns of others when acting as a consultant or utilizing consultant services
  - Willing to utilize consultant services when appropriate for patient care
  - Consistently manages patients as a consultant to other physicians/health care teams
  - Consistently applies risk assessment principles to patients while acting as a consultant

- Consistently formulates a clinical question for a consultant to address
- Provides consultation services for patients with clinical problems requiring basic risk assessment
- Asks meaningful clinical questions that guide the input of consultants
- Provides consultation services for patients with basic and complex clinical problems requiring detailed risk assessment
- Appropriately weighs recommendations from consultants in order to effectively manage patient care
- Switches between the role of consultant and primary physician with ease
- Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment
- Manages discordant recommendations from multiple consultants

Patient Care PC-1

- **How To Teach**
  - Discussions in ward rounds to teach history taking.
  - Discussions in ward rounds to teach physical examination.
  - Demonstration in ward rounds to teach history taking.
  - Demonstration in ward rounds to teach physical examination.
  - Discussions in wards of short cases
  - Discussions in wards of long cases
  - Simulated patient (in order to simulate a set of symptoms or problems.)
  - Should write a summary (synthesize a differential diagnosis).
- **How To Assess**
  - Discussions in ward rounds to assess history taking
  - Discussions in ward rounds to assess physical examination
  - Short cases assessment through long cases
  - Confirmation of physical findings by supervisor
  - Confirmation of history by supervisor.
  - OSPE

Mini- CEX

Patient Care PC-2

- **How To Teach**
  - Resident should write management plan on history sheet and supervisor should discuss management plan.
  - Resident should write investigational plans, should be able to interpret with help
  - of supervisor
  - Should be taught prioritization of care plans in complex patient by discussion.
- **How To Assess**
  - Long cases and short cases to assess the clear concepts of management by the trainee.(CBD, Mini-CEX)
- **Patient Care PC-3**
- **How To Teach**

- Discuss thoroughly the management side effects /interactions/dosage/therapeutic procedures and intervention

- **How To Assess**
  - Long case
  - Short case
  - OSPE
  - Simulated patient
  - Stimulated chart recall
  - Log book
  - Portfolio
  - Internal assessment record

- **Patient Care PC-4**

- **How To Teach**
  - Supervisor should ensure that the resident has complete knowledge about the procedures.
  - Trainee should observe procedures
  - Should perform procedures under supervision
  - Should be able to perform procedures independently
  - Videos regarding different procedures.

- **How To Assess**
  - OSPE
  - Logbook/ portfolio
  - Direct observation of practical skills

DOPS

Patient Care PC-5

How to Teach

- All consultations by the trainees should be discussed by the supervisor.

How to Assess

- Consultation record of the log book
- Feedback by other department regarding consultation

COMPETENCY NO. 2 MEDICAL KNOWLEDGE(MK)

- **Clinical knowledge (MK1)**

- Possesses sufficient scientific, socioeconomic and behavioral knowledge required to provide care for common medical conditions and basic preventive care.
- Possesses the scientific, socioeconomic and behavioral knowledge required to provide care for complex medical conditions and comprehensive preventive care
- Possesses the scientific, socioeconomic and behavioral knowledge required to successfully diagnose and treat medically uncommon, ambiguous and complex conditions.
- Knowledge of diagnostic testing and procedures. (MK2)
- Consistently interprets basic diagnostic tests accurately
- Does not need assistance to understand the concepts of pre-test probability and test performance Characteristics
- Fully understands the rationale and risks associated with common procedures
- Interprets complex diagnostic tests accurately
- Understands the concepts of pre-test probability and test performance characteristics
- Teaches the rationale and risks associated with common procedures and anticipates potential complications when performing procedures
- Anticipates and accounts for pitfalls and biases when interpreting diagnostic tests and procedures
- Pursues knowledge of new and emerging diagnostic tests and procedures

- **Medical Knowledge (MK-1, MK-2)**
- **How to Teach**
  - Books etc.
  - Articles
  - CPC(Clinic Pathological Conference)
  - Lecture
  - Videos
  - SDL(Self Directed Learning)
  - PBL(Problem Based Learning)
  - Teaching experience with medical student
  - Read procedural knowledge.
- **How To Assess**
  - MCQs
  - SEQs
  - Viva
  - Videos
  - Internal assessment

<u>COMPETENCY NO. 3</u> **<u>SYSTEM BASED PRACTICE</u>(SBP)**

- **Works effectively within an interprofessional team (e.g. peers, consultants, nursing, Ancillary professionals and other support personnel). (SBP1).**

- Recognizes the contributions of other inter professional team members
- Does not frustrates team members with inefficiency and errors
- Identifies roles of other team members and recognize how/when to utilize them as resources.
- Does not requires frequent reminders from team to complete physician responsibilities (e.g. talk to family, enter orders)
- Understands the roles and responsibilities of all team members and uses them effectively
- Participates in team discussions when required and actively seek input from other team members
- Understands the roles and responsibilities of and effectively partners with, all members of the team
- Actively engages in team meetings and collaborative decision-making
- Integrates all members of the team into the care of patients, such that each is able to maximize their skills in the care of the patient
- Efficiently coordinates activities of other team members to optimize care
- Viewed by other team members as a leader in the delivery of high quality care

- **Recognizes system error and advocates for system improvement. (SBP2)**
  - Does not ignore a risk for error within the system that may impact the care of a patient.
  - Does not make decisions that could lead to error which are otherwise corrected by the system or supervision.
  - Does not resistant to feedback about decisions that may lead to error or otherwise cause harm.
  - Recognizes the potential for error within the system.
  - Identifies obvious or critical causes of error and notifies supervisor accordingly.
  - Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk.
  - Willing to receive feedback about decisions that may lead to error or otherwise cause harm.
  - Identifies systemic causes of medical error and navigates them to provide safe patient care.
  - Advocates for safe patient care and optimal patient care systems
  - Activates formal system resources to investigate and mitigate real or potential medical error.
  - Reflects upon and learns from own critical incidents that may lead to medical error.
  - Advocates for system leadership to formally engage in quality assurance and quality improvement activities.
  - Viewed as a leader in identifying and advocating for the prevention of medical error.
  - Teaches others regarding the importance of recognizing and mitigating system error.
- **Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care. (SBP3).**
  - Does not ignores cost issues in the provision of care
  - Demonstrates effort to overcome barriers to cost- effective care
  - Has full awareness of external factors (e.g. socio- economic, cultural, literacy, insurance status) that impact the cost of health care and the role that external stakeholders (e.g. providers, suppliers, financers, purchasers) have on the cost of care
  - Consider limited health care resources when ordering diagnostic or therapeutic interventions

- Recognizes that external factors influence a patient's utilization of health care and Does not act as barriers to cost- effective care
- Minimizes unnecessary diagnostic and therapeutic tests
- Possesses an incomplete understanding of cost- awareness principles for a population of patients (e.g. screening tests)
- Consistently works to address patient specific barriers to cost-effective care
- Advocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)
- Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening tests
- Teaches patients and healthcare team members to recognize and address common barriers to cost- effective care and appropriate utilization of resources
- Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective high quality care

- **Transitions patients effectively within and across health delivery systems. (SBP4)**
  - Regards need for communication at time of transition
  - Responds to requests of caregivers in other delivery systems
  - Inconsistently utilizes available resources to coordinate and ensure safe and effective patient care within and across delivery systems
  - Written and verbal care plans during times of transition are complete
  - Efficient transitions of care lead to only necessary expense or less risk to a patient (e.g. avoids duplication of tests readmission)
  - Recognizes the importance of communication during times of transition
  - Communication with future caregivers is present but with lapses in pertinent or timely information
  - Appropriately utilizes available resources to coordinate care and ensures safe and effective patient care within and across delivery systems
  - Proactively communicates with past and future care givers to ensure continuity of care
  - Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency and ensure high quality patient outcomes
  - Anticipates needs of patient, caregivers and future care providers and takes appropriate steps to address those needs
  - Role models and teaches effective transitions of care
- **How To Teach**
  - Lecture/ orientation session
  - Various system/policies should be identified and discussed with the residents.
  - Examples:
  - Zakaat
  - Admission procedure
  - Bait-ul-Mall
  - Discharge procedure
  - Consultation procedure
  - Shifting of patients according to SOPS
  - Preferably a manual should be designed regarding various systems existing in the

- Hospital for the resident.
- Cost effectiveness/availability of medicine
- Avoidance of unnecessary tests because of limited health resources.
- Direct observation by the supervisor during ward rounds
- Feed back
- Assessment during case discussion

COMPETENCY NO. 4 PRACTICE BASED LEARNING (PBL)

- **Monitors practice with a goal for improvement. (PBLI1)**
  - Willing to self-reflect upon one's practice or performance
  - Concerned with opportunities for learning and self-improvement
  - Unable to self-reflect upon one's practice or performance
  - Avails opportunities for learning and self-improvement
  - Consistently acts upon opportunities for learning and self-improvement
  - Regularly self-reflects upon one's practice or performance and consistently acts upon those reflections to improve practice
  - Recognizes sub-optimal practice or performance as an opportunity for learning and self-improvement
  - Regularly self-reflects and seeks external validation regarding this reflection to maximize practice improvement
  - Actively engages in self- improvement efforts and reflects upon the experience
- **Learns and improves via performance audit. (PBLI2)**
  - Regards own clinical performance data
  - Demonstrates inclination to participate in or even consider the results of quality improvement efforts
  - Adequate awareness of or desire to analyze own clinical performance data
  - Participates in a quality improvement projects
  - Familiar with the principles, techniques or importance of quality improvement
  - Analyzes own clinical performance data and identifies opportunities for improvement
  - Effectively participates in a quality improvement project
  - Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients Analyzes own clinical performance data and actively works to improve performance
  - Actively engages in quality improvement initiatives
  - Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients
  - Actively monitors clinical performance through various data sources
  - Is able to lead a quality improvement project

- Utilizes common principles and techniques of quality improvement to continuously improve care for a panel of patients

- **Learns and improves via feedback. (PBLI3)**
  - Does not resists feedback from others
  - Often seeks feedback
  - Never responds to unsolicited feedback in a defensive fashion
  - Temporarily or superficially adjusts performance based on feedback
  - Does not solicits feedback only from supervisors
  - Is open to unsolicited feedback
  - Solicits feedback from all members of the interprofessional team and patients
  - Consistently incorporates feedback
  - Performance continuously reflects incorporation of solicited and unsolicited feedback
  - Able to reconcile disparate or conflicting feedback
- **Learns and improves at the point of care. (PBLI4)**
  - Acknowledges uncertainly and does not revert to reflexive patterned response when inaccurate
  - Seeks or applies evidence when necessary
  - Familiar with strengths and weaknesses of the medical literature
  - Has adequate awareness of or ability to use information technology
  - Does not accepts the findings of clinical research studies without critical appraisal Can translate medical information needs into well- formed clinical questions independently
  - Aware of the strengths and weaknesses of medical information resources and utilizes information technology with sophistication
  - Appraises clinical research reports, based on accepted criteria
  - Does not "slows down" to reconsider an approach to a problem, ask for help, or seek new information
  - Routinely translates new medical information needs into well-formed clinical questions
  - Utilizes information technology with sophistication
  - Independently appraises clinical research reports based on accepted criteria
  - Searches medical information resources efficiently, guided by the characteristics of clinical questions
  - Role models how to appraise clinical research reports based on accepted criteria
  - Has a systematic approach to track and pursue emerging clinical question
- **Practice Based Learning (PBL1, PBL2, PBL3, PBL4)**
  - **How to Teach**
    - Discussions about problem cases
    - Should discuss errors and omissions
  - **How to Assess**

- Feed back
- 360 evaluation
- Research article presentation
- Journal club presentation
- CPC presentation
- Ward presentation
- Quality improvement of projects

COMPETENCY NO. 5 PROFESSIONALISM(PROF)

- Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel). (PROF1)
- Consistently respectful in interactions with patients, caregivers and members of the interprofessional team, even in challenging situations
- Is available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective care Emphasizes patient privacy and autonomy in all interactions
- Demonstrates empathy, compassion and respect to patients and caregivers in all situations
- Anticipates, advocates for, and proactively works to meet the needs of patients and caregivers
- Demonstrates a responsiveness to patient needs that supersedes self-interest
- Positively acknowledges input of members of the interprofessional team and incorporates that input into plan of care as appropriate
- Role models compassion, empathy and respect for patients and caregivers
- Role models appropriate anticipation and advocacy for patient and caregiver needs
- Fosters collegiality that promotes a high-functioning interprofessional team

- **Teaches others regarding maintaining patient privacy and respecting patient autonomy Accepts responsibility and follows through on tasks. (PROF2)**
  - Demonstrates responsibilities expected of a physician professional
  - Accepts professional responsibility even when not assigned or not mandatory
  - Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy
  - Completes assigned professional responsibilities without questioning or the need for reminders
  - Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner
  - Willingness to assume professional responsibility regardless of the situation
  - Role models prioritizing multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner
  - Assists others to improve their ability to prioritize multiple, competing tasks

- **Responds to each patient's unique characteristics and needs. (PROF3)**
    - Willing to modify care plan to account for a patient's unique characteristics and needs
    - Is sensitive to and has basic awareness of differences related to culture, ethnicity, gender, race, age and religion in the patient/caregiver encounter
    - Seeks to fully understand each patient's unique characteristics and needs based upon culture, ethnicity, gender, religion, and personal preference
    - Modifies care plan to account for a patient's unique characteristics and needs with complete success
    - Recognizes and accounts for the unique characteristics and needs of the patient/ caregiver
    - Appropriately modifies care plan to account for a patient's unique characteristics and needs
    - Role models professional interactions to negotiate differences related to a patient's unique characteristics or needs
    - Role models consistent respect for patient's unique characteristics and needs
- **Exhibits integrity and ethical behavior in professional conduct. (PROF4)**
    - Has a basic understanding of ethical principles, formal policies and procedures, and does not intentionally disregard them
    - Honest and forthright in clinical interactions, documentation, research, and scholarly activity
    - Demonstrates accountability for the care of patients
    - Adheres to ethical principles for documentation, follows formal policies and procedures, acknowledges and limits conflict of interest, and upholds ethical expectations of research and scholarly activity
    - Demonstrates integrity, honesty, and accountability to patients, society and the profession
    - Actively manages challenging ethical dilemmas and conflicts of interest
    - Identifies and responds appropriately to lapses of professional conduct among peer group
    - Assists others in adhering to ethical principles and behaviors including integrity, honesty, and professional responsibility
    - Role models integrity, honesty, accountability and professional conduct in all aspects of professional life
    - Regularly reflects on personal professional conduct

- **Professionalism (PROF1, PROF2, PROF3 AND PROF4)**
- **How To Teach**
    1. Should be taught during ward rounds.
        - By supervisor
        - Through workshops
- **How To Assess**
    1. Punctuality
    2. Behavior
    3. Direct observation during ward rounds
    4. Feed back
    5. 360 degree evaluation

Competency No. 6 INTERPERSONAL AND COMMUNICATION SKILL (ICS)

- Communicates effectively with patients and caregivers. (ICS1)
- Does not ignores patient preferences for plan of care
- Makes attempt to engage patient in shared decision-making
- Does not engages in antagonistic or counter-therapeutic relationships with patients and caregivers
- Engages patients in discussions of care plans and respects patient preferences when offered by the patient, and also actively solicit preferences.
- Attempts to develop therapeutic relationships with patients and caregivers which is often successful
- Defers difficult or ambiguous conversations to others
- Engages patients in shared decision making in uncomplicated conversations
- Requires assistance facilitating discussions in difficult or ambiguous conversations
- Requires guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds
- Identifies and incorporates patient preference in shared decision making across a wide variety of patient care conversations
- Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds
- Incorporates patient-specific preferences into plan of care
- Role models effective communication and development of therapeutic relationships in both routine and challenging situations
- Models cross-cultural communication and establishes therapeutic relationships with persons of diversesocioeconomic backgrounds

- **Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel). (ICS2**)
    - Does not uses unidirectional communication that fails to utilize the wisdom of the team
    - Does not resists offers of collaborative input
    - Consistently and actively engages in collaborative communication with all members of the team
    - Verbal, non-verbal and written communication consistently acts to facilitate collaboration with the team to enhance patient care
    - Role models and teaches collaborative communication with the team to enhance patient care, even in challenging settings and with conflicting team member opinions

- **Appropriate utilization and completion of health records. (ICS3)**
    - Health records are organized and accurate and are not superficial and does not miss key data or fails to communicate clinical reasoning
    - Health records are organized, accurate, comprehensive, and effectively communicate clinical reasoning
    - Health records are succinct, relevant, and patient specific
    - Role models and teaches importance of organized, accurate and comprehensive health records that are succinct and patient specific

Interpersonal and Communication Skill (ISC1, ICS2 AND ICS3)

- **How to Teach**
    - Teaching through communication skills by supervisor
    - Through workshop
- **How to Assess**
    1. Direct observation
    2. Feed back
    3. 360 degree evaluation
    4. History taking
    5. CPC presentation
    6. Journal club presentation
    7. Article presentation
    8. Consultation
    9. OPD working
    10. Counseling sessions
    11. OSPE
    12. VIVA

SECTION-1

MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR

SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-2

TOPIC PRESENTATION/SEMINAR

SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
Allocation of topic according to different section of Gastrointestinal & Hepatology diseases Every PGT should present atleast one topic from every section				
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SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-3

JOURNAL CLUB(includes all aspects of Gastrointestinal & Hepatology diseases , guidelines, interventions, drugs and endoscopy)

SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-4

PROBLEM CASE DISCUSSION

SR #	DATE	REG.# OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR #	DATE	REG.# OF THE PATIENT Discussed	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR #	DATE	REG.# OF THE PATIENT Discussed	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR #	DATE	REG.# OF THE PATIENT Discussed	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-5

DIDACTIC LECTURES/INTERACTIVE LECTURES

SR #	DATE	TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR #	DATE	TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR #	DATE	TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-6

RECORD OF TOTAL EMERGENCY CASES ATTENDED ON EMERGENCY CALL DAYS

(Estimated cases to be attended on call days 10 patients per day)EMERGENCY CASES (Repetition of Cases Should Be Avoided)

SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION 6 :

EMERGENCY CASES (Repetition of cases should be avoided) (Estimated 50 cases to be documented)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-7

RECORD OF TOTAL INDOOR CASES ATTENDED ON CALL DAYS IN THE WARD

(Estimated cases to be attended on call days 50 patients per year)

SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-7

INDOORPATIENTS (repetition of cases should be avoided)
(Estimated cases to be attended are 50 patients per year)

SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SECTION-8

RECORD OF TOTAL OPD/CLINICCASES ATTENDEDON OPD CALL DAYS

(Required number of cases in OPD at least 100 cases/month)

SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED	SUPERVISOR'S SIGNATURE (Name/Stamp)
1			
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
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SR.#	DATE	TOTAL NUMBER OF CASES ATTENDED WITH BRIEF DETAIL	SUPERVISOR'S SIGNATURE (Name/Stamp)
298			
299			
300			

SECTION-8

OPD AND CLINICS(repetition of cases should be avoided)

(Estimated cases to be attended are 100 patients per month)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
1					
2					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
6					
7					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
11					
12					
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14					
15					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
16					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
22					
23					
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27					

R#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
28					
29					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
34					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
40					
41					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
46					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
52					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
58					
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63					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
64					
65					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
70					
71					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
76					
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SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
82					
83					
84					
85					
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87					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
88					
88					
89					
90					
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92					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
93					
94					
95					
96					
97					
98					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
99					
100					
101					
102					
103					
104					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
105					
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110					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
111					
112					
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114					
115					
116					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
117					
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121					
122					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
123					
124					
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128					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
129					
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134					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
135					
136					
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140					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
141					
142					
143					
144					
145					
146					

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
146					
148					
149					
150					

SECTION-9

PROCEDURES

OBSERVED (O)/ASSISTED (A)/ PERFORMED UNDER SUPERVISION (PUS)/PERFORMED INDEPENDENTLY (PI)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/(PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/(PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS) /(PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/(PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-10

MULTI DICIPLINARY MEETINGS

SR#	DATE	BRIEF DESCRIPTION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	BRIEF DESCRIPTION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-11

CLINICOPATHOLOGICAL CONFERENCE (CPC)

(50% attendance of CPC is mandatory for the resident every year)

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'SSIGNATURE (Name/Stamp)
1			
2			
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SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)
6			
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11			

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)
12			
13			
14			
15			
16			
17			

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)
18			
19			
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23			

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)
24			
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29			

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)
30			

SECTION-12

MORBIDITY/MORTALITY MEETINGS

(Total Morbidity/Mortality Meetings to be attended TWO Morbidity/Mortality Meetings permonth)

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
1					
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5					

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
6					
7					
8					

9					
10					

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
11					
12					
13					
14					
15					
16					

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
17					
18					
19					
20					
21					
22					

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
23					
24					
25					
26					
27					

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
28					
29					
30					

SECTION-13

HANDS ON TRAINING/WORKSHOPS

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
1						
2						
3						
4						
5						

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
6						
7						
8						
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SECTION-14

PUBLICATIONS

SNO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE /EDITORIAL/CASE REPORT	NAME OF JOURANL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SNO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE /EDITORIAL/CASE REPORT ETC	NAME OF JOURANL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-15

MAJOR RESEARCH PROJECT DURING MD TRAINING/ANY OTHER MAJOR RESEARCH PROJECT

SNO.	RESEARCH TOPIC	PLACE OF RESEARCH	NAME AND DESIGNATION OF SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SNO.	RESEARCH TOPIC	PLACE OF RESEARCH	NAME AND DESIGNATION OF SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-16

WRITTEN ASSESSMENT RECORD

S.NO	TOPIC OF WRITTEN TEST/EXAMINATION	TYPE OF THE TEST MCQS OR SEQS OR BOTH	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

S.NO	TOPIC OF WRITTEN TEST/EXAMINATION	TYPE OF THE TEST MCQS OR SEQS OR BOTH	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-17

CLINICAL ASSESSMENT RECORD

SR.#	DATE	TOPIC OF CLINICAL TEST/ EXAMINATION	TYPE OF THE TEST& VENUE (OSPE, MINICEX, CHART STIMULATED RECALL, DOPS, SIMULATED PATIENT, SKILL LAB, ACAT, MSF, CbD e.t.c)	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	TOPIC OF CLINICAL TEST/ EXAMINATION	TYPE OF THE TEST& VENUE OSPE, MINICEX, CHART STIMULATED RECALL, DOPS, SIMULATED PATIENT, SKILL LAB e.t.c	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-18

Evaluation records

To Be Filled At the End of 1st Year of Training

RAWALPINDI MEDICAL UNIVERSITY

SUPERVISOR APPRAISAL FORM

Resident's Name: _____ Hospital Name: _____

Evaluator's Name(s): _____ Department: _____ Unit : _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1
a) Sets and adheres to protocols and improving the skills					
b)Exhibits system based learning methods smartly					
c)Exhibits practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes satisfactory management of different GI cases with assistance or supervision					

j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					
e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____ _____ _____ _____

Date Resident's Name &Signatures Date Evaluator's Signature &Stamp

RAWALPINDI MEDICAL UNIVERSITY
SUPERVISOR APPRAISAL FORM

To Be Filled At The End Of 2nd Year Of Training

Resident's Name: _____ **Hospital Name:** _____
Evaluator's Name(s): _____ **Department :**_____ **Unit :** _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1
a) Sets and adheres to protocols and improving the skills					
b)Exhibits system based learning methods smartly					
c)Exhibits practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes satisfactory management of different GI cases with minimal assistance or supervision					

j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					
e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____ _____ _____ _____

Date Resident's Name &Signatures Date Evaluator's Signature &Stamp

RAWALPINDI MEDICAL UNIVERSITY
SUPERVISOR APPRAISAL FORM

To Be Filled At The End Of 3rd Year Of Training

Resident's Name: _____ **Hospital Name:** _____
Evaluator's Name(s): _____ **Department :**_____ **Unit :** _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1
a) Sets and adheres to protocols and improving the skills					
b)Exhibits system based learning methods smartly					
c)Exhibits practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes satisfactory management of different GI cases with minimal assistance or supervision					

j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					
e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____ _____ _____ _____

Date Resident's Name &Signatures Date Evaluator's Signature &Stamp

SECTION-18

EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)

(AT THE END OF 1ST YEAR OF TRAINING)

SECTION-18

EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)

(AT THE END OF 2ND YEAR OF TRAINING)

SECTION-18

EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)

(AT THE END OF 3RD YEAR OF TRAINING)

SECTION=18

EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) (AT THE END OF 1ST YEAR OF TRAINING)

SECTION=18

EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)

(AT THE END OF 2ND YEAR OF TRAINING)

SECTION-18

EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)

(AT THE END OF 3RD YEAR OF TRAINING)

SECTION-19

LEAVE RECORD

(Signed & Approved Leave Application/Certificate to Be Kept In Record and To Be Brought In Meetings with URTMC & QEC)

SR.#	TYPE OF LEAVE(Casual Leave,Sick Leave,Ex –Pak Leave,Maternity Leave, Any Other Kind Of Leave)	YEAR	DATE		REASON	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
			FROM	TO			

SECTION-20

Year - I

RECORD SHEET OF ATTENDANCE/COUNCELLING SESSION/DOCUMENTATION QUALITY PER YEAR

TO BE FILLED AT THE END OF FIRST YEAR OF TRAINING

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
November	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

TO BE FILLED AT THE END OF SECOND YEAR OF TRAINING

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
November	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

TO BE FILLED AT THE END OF THIRD YEAR OF TRAINING

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
November	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-21

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAI