WESTERN UNIVERSITY

DEPARTMENT of PEDIATRICS

MID ROTATION RESIDENT EVALUATION MEETING NOTE

Resident: _____

Clinical Rotation: _____ **Rotation Dates:** _____

Number of days absent (excluding post call days): _____

MEETING NOTE:

Resident Signature:_____ **Date:**_____

Supervisor Name: _____ **Supervisor Signature:** _____
PRINT

** Complete and return to Belle Smaill (fax:*519-685-8156*, belle.smaill@lhsc.on.ca*)