Medical Teaching Feedback Form PDF

Course Information

Course Title: _____

Instructor's Name: _____

Semester/Year: _____

Participant Information

Name (Optional): _____

Role (e.g., Student, Resident): _____

Date: _____

Teaching Evaluation

Aspect	Rating (1-5)	Comments
Clinical Knowledge	_____	_____
Teaching Skills	_____	_____
Communication	_____	_____
Approachability	_____	_____

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Practical Skills Training	_____	_____
Use of Teaching Materials	_____	_____
Professionalism	_____	_____
Overall Satisfaction	_____	_____

Positive Feedback

_____

_____

Suggestions for Improvement

_____

_____

Additional Feedback

_____

_____

Signature (Optional)

Signature: _____

Checklist for Medical Skills Covered

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Skill	Covered	Comments	Follow-Up Required
Patient Examination	[ ]	_____	[ ]
Diagnosis Techniques	[ ]	_____	[ ]
Treatment Planning	[ ]	_____	[ ]
Surgical Skills	[ ]	_____	[ ]
Emergency Procedures	[ ]	_____	[ ]
Use of Medical Equipment	[ ]	_____	[ ]
Patient Communication	[ ]	_____	[ ]
Medical Documentation	[ ]	_____	[ ]

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