

PENNSYLVANIA AHEC

CLINICAL EXPERIENCE REPORTING FORM (EXIT) CR - 2

AHEC Region Use Only:

Code: _____

The Pennsylvania AHEC, in partnership with your school, is seeking to help meet the primary care needs of our communities and to make health careers training a more valuable experience. Results from this survey will be used to support these goals. **All survey responses are confidential.** Data will only be used within the AHEC program and never for commercial purposes.

Please answer each item as completely as possible. Please print all responses.

Date Completed: ___/___/___
Month Day Year

1. Your Name _____
Last Name

First Name Middle Name

2. What is the name(s) of your preceptor(s) responsible for this rotation?

2a. Preceptor Name: _____
First Last

2b. Preceptor Name: _____
First Last

3. What is the name of the facility where your rotation took place?

Name of facility: _____

4. What were the start and end dates of this clinical experience (rotation)?

Start Date: ___/___/___ End Date: ___/___/___
Month Day Year Month Day Year

5. How much clinical time did you spend in this training/clinical experience? (If less than 1 day enter "1".)

___ ___ days

6. Please rate the clinical experience (rotation) you just completed with respect to the following:

	Extremely Dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely Satisfied	Does Not Apply
a. Achievement of the learning objectives intended or stated for this experience	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b. Achievement of my personal learning objectives	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c. Accessibility of on-site learning resources (Internet, tutorials, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
d. Accessibility of preceptor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
e. Opportunity to deliver hands-on patient care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

7. Please rate the following attributes of your housing for the rotation you just completed. *If housing was not provided for you, Please mark "Does Not Apply".*

	Extremely Dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely Satisfied	Does Not Apply
a. Accessibility of internet and other learning resources from my housing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b. Quality/Condition of housing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c. Safety of housing/community	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

8. Was the clinical experience (rotation) you just completed labeled as (or could best be considered) which of the following?

- | | |
|---|--|
| <input type="checkbox"/> Family Medicine (1) | <input type="checkbox"/> General Internal Medicine (2) |
| <input type="checkbox"/> General Pediatrics (3) | <input type="checkbox"/> General Surgery (4) |
| <input type="checkbox"/> Psychiatry (5) | <input type="checkbox"/> OB/GYN (6) |
| <input type="checkbox"/> General Dentistry (7) | <input type="checkbox"/> Nursing (8) |
| <input type="checkbox"/> Other _____ (9) | |

9. What was your status during this rotation? *If undergraduate studies exceed four years, please select 'Other' and provide an explanation. Undergraduate refers to medical school as well as a college or university program.*

- | | |
|--|---|
| <input type="checkbox"/> First Year Undergraduate (1) | <input type="checkbox"/> Post Graduate Year 2 (6) |
| <input type="checkbox"/> Second Year Undergraduate (2) | <input type="checkbox"/> Post Graduate Year 3 (7) |
| <input type="checkbox"/> Third Year Undergraduate (3) | <input type="checkbox"/> Post Graduate Year 4 (8) |
| <input type="checkbox"/> Fourth Year Undergraduate (4) | <input type="checkbox"/> Post Graduate Year 5 (9) |
| <input type="checkbox"/> Post Graduate Year 1 (5) | <input type="checkbox"/> Other _____ (10) |

10. Has the clinical rotation you just completed influenced your feelings about the probability that you might practice in one of the following areas upon graduation? *(Please answer all.)*

	Made It less Likely	No Influence	Made it More Likely
a. In Pennsylvania	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. In a rural area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. In an urban area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. In a medically underserved area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Thank you!

AHEC Region Use Only

Date Entered: ___ / ___ / ___
Month Day Year

Preceptor Code: _____

Site Code: _____

Entered by: _____