



**Self-Directed Clinical Traineeship
Learner`s Evaluation of the Activity (FP)**

Learner: _____ **Date:** _____

Preceptor: _____ **Site/Location:** _____

	Yes	No	Comments
Was the traineeship organized to your satisfaction?	Yes	No	
Did this traineeship meet your expectations?	Yes	No	
Were all of your stated objectives met?	Yes	No	
Was there adequate clinical exposure?	Yes	No	
Was there adequate opportunity to practice procedures?	Yes	No	N/A

Overall, the preceptor(s) was:

Most valuable feature of the traineeship was:

Do you think you will make a change in your practice as a result of this traineeship?

Yes ____ In what manner?
No ____ Please comment.

Other comments:

<p>_____ Signature</p> <p>_____ Date</p>	<p>Please complete, sign and return to: CPD Medicine Program Continuing Competency and Assessment Rady Faculty of Health Sciences, University of Manitoba 260 Brodie Centre – 727 McDermot Ave, Wpg, MB R3E 3P5 Tel: (204)789-3238 ■ Fax: (204) 789-3911 Email: lenore.chipman@umanitoba.ca</p>
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