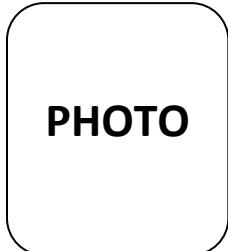


FORM 1B

**INTERNSHIP ASSESSMENT FORM FOR DENTIST/ MEDICAL DOCTOR
(INTERNSHIP LOGBOOK)**



YEAR _____

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

National ID No: _____ Issuing Date: _____

Physical Address: _____

Phone No: _____ Email: _____

Internship Registration No. _____ Internship Centre: _____

Discipline: _____

Period of Rotation, from: _____ to: _____

A. Initial Assessment:

GRADE: **A** - Very Good **B** - Good **C** - Satisfactory **D** - Unsatisfactory

NB: Where the grading shall be for scale **D** above, the Supervisor shall be required to give reasons for the said finding and make recommendations in the best interest of the intern and the public at large.

Description	Grade	Remarks
I. KNOWLEDGE		
• Basic Sciences		
• Theoretical Knowledge in the Discipline		



• Participation in CPD(Continuous Professional Development)		
II. CLINICAL SKILLS		
• History Taking		
• Clinical examination		
• Interpretation of laboratory Data and X-Ray findings		
• Patient notes		
• Use of drugs		
• Patient Management		
III. PROFESSIONAL CONDUCT		
a) To patients		
b) To seniors, colleagues and other health workers		
c) To public		
d) Punctuality & availability		

B. OVERALL ASSESSMENT BY THE SUPERVISOR

Name: _____ Qualification: _____

Reg. No. _____ Signature: _____ Date: _____

C. RECOMMENDATION BY THE INTERN COORDINATOR

Name: _____ Qualification: _____

Reg. No. _____ Signature: _____ Date: _____



D. HOSPITAL MEDICAL DIRECTOR/MEDICAL SUPERINTENDENT

I certify that the above-named officer was engaged in full-time training employment in the discipline specified above, in accordance with section II of CAP 253 and is hereby recommended/not recommended for registration. (delete if not applicable)

Name: _____ Qualification: _____

Reg. No. _____ Signature: _____ Date: _____

Official Stamp: _____