

CLINICAL MENTOR'S EVALUATION OF CAPSTONE PROJECT

Clinical Mentor's Name and Title: _____

Student Name: _____ Student ID # 901 _____

Project Title: _____

The student completed at least 90 hours of shadowing. YES NO

If NO, how many hours? _____

Please assess the student by assigning a point value (0-10) to each of items 1-5 below.

_____ 1. problem solving skills and the ability to analyze results critically

_____ 2. reflection, self awareness and self assessment abilities

_____ 3. the ability to apply knowledge to real-life experience

_____ 4. skills through some tangible product?

_____ 5. ability to collaborate, work on a team and listen effectively

Optional. If you as the clinical mentor were in a position to assess either of the following, please assign two points for each.

_____ 6. OPTIONAL effective writing skills as evidenced by their written report.

_____ 7. OPTIONAL effective oral communication skills as evidenced by his/her oral

report on this project which was presented to : _____

Date of oral presentation: _____

Total Points Earned: _____

Please use space below to comment on any aspect of your evaluation and/or any follow up or potential benefits derived by the student from this project. Attach a separate sheet if needed.

Clinical Mentor's Signature: _____ Date: _____

When completed, please either print this form, sign, and return via mail or Fax, or sign electronically by typing your name and emailing the saved pdf to:

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