Medicine

Medical

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic : Date: Name of teacher	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

MONTHLY ATTENDANCE RECORD

Month	Lectures		Wards		Remarks
February					
March					
April					
May					
June					
July					
August					
September					
Oct					

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book			Out of:				
	%age							

Deputy / Controller of examination

Sign_____

General Surgery

Surgical

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

MONTHLY ATTENDANCE RECORD

Month	Lectures		Wards		Remarks
February					
March					
April					
May					
June					
July					
August					
September					
Oct					

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book				Out of:			
	%age							

Deputy / Controller of examination

Sign_____

Gynecology and Obstetrics

Gynae

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Gynae / Obs. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Vaginal / Pelvic examination Obstetric examination						
		□						
		□						
		□						
		□						
		• Other (specify)						
4		Deliveries • Normal vaginal						
5		• Forceps						
6		• C. Sections						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Gynae / Obs.	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Session conducted on following: • Labor notes • Neonatal assessment • Placenta • Partograph • Post-delivery progress Daily reports	By:	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
Antenatal visits protocol	Presented by:	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

MONTHLY ATTENDANCE RECORD

Month	Lectures		Wards		Remarks
February					
March					
April					
May					
June					
July					
August					
September					
Oct					

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book			Out of:				
	%age							

Deputy / Controller of examination

Sign_____

Pediatrics

Pediatrics

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Paeds. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Dehydration status						
		• Examination of newborn ❖ Physical screening ❖ Hip examination						
		• Others (specify)						
r3		Growth parameters						
		• Height / length						
		• Weight						
		• Head circumference						
		• Use of centile charts						
		• Role play / counseling session						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
History taking- presentation	Presented by:	
Resuscitation (manikins)	Presented by:	
Growth parameters	Presented by:	
Exchange transfusions	Presented by:	
Integrated management of neonatal and childhood illnesses (IMNCI-under 2 months) / fever / sepsis / jaundice	Presented by:	
Advantages of breast feeding	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

MONTHLY ATTENDANCE RECORD

Month	Lectures		Wards		Remarks
February					
March					
April					
May					
June					
July					
August					
September					
Oct					

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book				Out of:			
	%age							

Deputy / Controller of examination

Sign_____

Orthopedics

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		History taking						
		General physical examination						
		• Others (specify)						
3		Application of cast						
		• X-ray reading						
		• Other (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to common problems in Orthopedics	Presented by:	
Management of fractures	Presented by:	
Orthopedic emergencies	Presented by:	
Details of 2 patient's histories and physical examination	Presented by:	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

CCU and Cardiology

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		• ECG						
		• Echo						
		• ETT						
		• Temporary pacemaker insertion						
		• Use of defibrillator						
		• Other (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
BCLS	Presented by:	
ACLS	Presented by:	
OTHERS: 1-	By:	
2-	By:	
3-	By:	
End of the ward assessment	Marks:_____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students (To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Nephrology

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		CVP / double lumen insertion						
		• Renal U/S						
		• RENAL BIOPSY						
		•						
		•						
		• Other (specify)						

*Student can paste the proof / certific **MONTHLY ATTENDANCE RECORD**

Month	Lectures		Wards		Remarks
February					
March					
April					
May					
June					
July					
August					
September					
Oct					

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book			**Out of:**				
	%age							

Deputy / Controller of examination

Sign_____

Other academic and co-curricular activities

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

*The student can paste photocopies of certificates of presentations on this page

List of certificates of participation in other academic and co-curricular activities*

S. No	Name of activity / society / other	Position	From ---------- to ----------	Signature of organizer / incharge