جـامعـة المعـرفـة
ALMAAREFA UNIVERSITY

College of Medicine
Clinical Department

Clinical Training Logbook

Student Name: _____

Student Number: _____

College Vision:

Provide a comfortable educational environment that enhances learning & professionalism promoting research and community services.

College Mission:

To graduate competent physicians with high ethical values in an effective educational environment, inspiring research and community services.

Contents

What is the logbook?

This is an important document. It provides a means of monitoring the scope and diversity of your learning experience. The logbook is integral to basic clinical training and will record your academic and educational activities. It is intended to submit written feedback about your performance at the internship site and is part of your portfolio.

The patient logbook will be reviewed, and patients› diagnoses will be summarized by diagnosis groups during the mid-rotation (after Paed1, Med1, and Surgery1) evaluation and at the end of the clerkship. This reflects the number of patients seen by category. The results of this review will be totaled in the summary chart.

Keep this logbook current as you go through your clerkship and review it frequently with the supervisor and clerkship coordinator. While there are no specific maximum numbers of patients for each category, you should have a minimum of at least one patient in each category and aim for a reasonably balanced distribution. This will add to what you learn in your core classes and help you build an excellent knowledge base.

In general, you should average at least three patients per week. Thus, you will be able to evaluate 30 or more patients during a -12week course clerkship.

What are the competencies in our curriculum?

By the end of his graduation, the student should be able to achieve the six main competencies and their sub-competencies.

Competencies	Sub-competencies
1. Scientific Approach to Practice	1. Integration of basic, clinical, behavioral and social sciences in medical practice. 2. Delivery of evidence-based care
2. Patient Care	1. Demonstration of basic clinical skills 2. Demonstration of clinical reasoning, decision making and problem-solving skills 3. Management of life-threatening medical life conditions 4. Management of common medical problems 5. Placing patient needs and safety at the center of the care process
3. Community-oriented practice	1. Understand the health care system in Saudi Arabia 2. Advocacy of health promotion and disease prevention
4. Communication and collaboration	1. Effectively communicate with patients, colleagues, and other health professionals 2. Teamwork and inter-professional collaboration 3. Application of medical informatics in the health care system
5. Professionalism	17. Adherence to professional attitude and behaviors of physicians 18. Application of Islamic, legal and ethical principal of the professional practice. 19. Commitment to personal and professional development.
6. Research and scholarship	1. Demonstration of basic research skills

Within the competencies lie 80 specific learning outcomes that medical students must complete.

Instructions for the use of logbook

Aim of the logbook

The purpose of the logbook is to provide one source of evidence for the department that you attained the desired level of competency required for a final-year medical student. It is the place where you are going to document the experiences and skills you gained during your training.

Personnel information

For evaluation purposes, please fill in all your personnel information required on page 1.

Clinical case log

1. You will find lists with all required cases in the curriculum. You should be exposed and record at least 3 variable cases/week. Your trainer will determine your level of participation in each case.
2. Patient name is not required; only record the hospital ID and date of the interview. It would help if you mentioned the case provisional and final diagnosis to gather with the management provided. In case of emergency, admissions only write the diagnosis of the case.
3. Mark a check at the appropriate column indicating your level of participation in the case presentation (observer, presented).
4. Your clinical trainer should countersign each case. His signature is proof of your actual participation.

Procedures/operations log

1. The logbook contains tables for required procedures during different training stages and the desired performance level at each location.
2. You will also find empty tables to write down the procedures, your level of participation and the date. Your trainer should countersign each procedure to document the event.

Rotation Proof

At the end of the rotation, official signs the log by the Hospital/training center manager & stamp

Assessment of logbook activities

The examination committee of the department will revise your logbook at the end of training before the final exam. The coordinator at mid-final term or on a weekly basis might look at:

1. Full attendance
2. Discuss a case from your logbook
3. Number and variety of clinical contacts and reviews
4. Professional behavior/performance in the internship
5. Good points and areas for improvement

Important Notice:

It is your responsibility to maintain an accurate and completed logbook and to update your records regularly. You must contact your trainer (clerkship coordinator) or course coordinator if you meet any difficulties.

Obligations and Commitments (تعهدات والتزامات)

Obligations and Commitments of the student towards the training center:

1 The student is obligated to follow all the rules and regulations in force in the training center.

2 The student must keep all in-kind and tangible property in the training center and pay financial compensation in case of damage to the employer's property without Almaarefa University bearing any financial and legal responsibility, full or partial.

I am .....

University Id .....

I pledge to abide by what is stated in this pledge as long as there is no responsibility for the College of Medicine or the Almaarefa University

Student signature.....

التزامات وتعهدات الطالب تجاه مركز التدريب:

1 يلتزم الطالب باتباع جميع الأنظمة واللوائح المعمول بها في مركز التدريب.

2 يجب على الطالب الاحتفاظ بجميع الممتلكات العينية والمادية في مركز التدريب ودفع تعويض مالي في حالة الإضرار بممتلكات صاحب العمل دون أن تتحمل جامعة المعرفة أي مسؤولية مالية او قانونية كاملة أو جزئية.

انا الطالب .....

الرقم الجامعي .....

اتعهد بالالتزام بما جاء في في هذا التعهد دنما اي مسؤولية لكلية الطب او جامعة المعرفة

توقيع الطالب .....

Assessment Medical Expert (item 1-4) Rubric

1. History Taking

1	2	3	4	5
Many irrelevant questions	Mostly relevant questions	All questions are relevant	Correct questions	Adequate and efficient
Incomplete	Rate still too slow	Reasonable rate	Systematically and clear	Excellent rate
Very slow rate	Still little System/ coherence	System/ coherence presents	Rate good	Full of confidence
System/ coherence is lacking	Regularly guidance is needed	Little guidance needed	No real guidance is needed	Has an overview
Much guidance is needed				Can respond flexibly to unexpected situations
Disturbing for the patient				

2. Physical Examination

1	2	3	4	5
Perform (many) irrelevant procedures/ investigations	Mainly relevant procedures/ investigations	Adequate, relevant procedures/ investigations	Adequately relevant procedures/ investigations	Adequately relevant procedures/ investigations
Performance technical inadequate	Not always technical adequate	Identify the relevant findings	Draws correct conclusions	Efficient with a good Pace
Much correction is needed	Miss relevant findings	Still a bit slow pace	Pace not yet optimal	Has an overview
Nuisance/ harmful to the patient	Slow pace	Little guidance is needed	No guidance is needed	Can respond flexibly to unexpected situations
	Regular guidance is needed	Good contact with the patient	Give adequate instructions to the patient	Recognizes the patient`s discomfort, keep eye contact, and adequately instructs and explain to the patient.
	No adequate communication with the patient			

3. Differential diagnosis

1	2	3	4	5
Miss important findings	Miss important findings	Can distinguish relevant findings	Adequate interpretation of relevant findings	Quick and correct interpretation of problems, even the complex ones
Lack of adequate findings` interpretation	Lack of adequate findings` interpretation	Ability to correctly interpret the findings.	Without guidance, a correct problem list and differentials with adequate motivation related to the complaints and findings.	Fast overview of essential findings with adequate motivation.
Incoherent and unsubstantiated problem list and differentials	Incoherent and unsubstantiated problem list and differentials	Problem list and differentials are well related to the complaints and findings.	Only complex circumstances guidance is needed	Clear good knowledge and self-confidence.
Too slow	Too slow	Limited guidance is needed		
Much guidance is needed	Much guidance is needed			

4. Plan

1	2	3	4	5
› Cannot make an adequate plan › Miss knowledge › Much guidance is needed › Possible Nuisance/ harmful to the patient.	› Can only partly make an adequate plan. › Incomplete knowledge › Regular guidance is needed	› Can make an adequate plan with sufficient motivation. › Limited guidance is needed	› Can make an adequate plan relevant to the findings with sufficient motivation. › No guidance is needed	› Can make an adequate plan fitting the need and personal situation of the patient. › Clear and good motivation › Fully accepted by the patient.

Professional behavior with patients
5. Patient communication

1	2	3	4	5
› Little structure recognizable › Does not ask about the exact complaints › No summaries	› Little structure which is lost during conversion. › Insufficient exploration of complaints. › Few summaries, too much self-centered. › Many disturbing minutes of silence during the conversation. › No sense of the patient's emotions	› Although stiff, the structure is present with sufficient exploration and summaries. › Recognizes emotions and informs the patients, although not always in an understandable way › Empathic	› Good structure, exploration and summaries. › Adequate information to the patient. › Recognizes non-verbal signals and emotions from the patient and addresses this adequately. › Empathic	› Fully natural communications. Flexible with room for the patient's comments. › Good structure. › Good interview skills demonstrated. › Gives sufficient understandable information to the patients. › Empathic

Professional behavior Overall
6. Professional behavior

1	2	3	4	5
› Does not keep appointments (time appearance, preparation) › Not respectfully: discriminating, evading behavior (to patients' supervisors or colleagues) (to patients supervisors or colleagues) › Aggressive behavior › Inappropriate appearance › Not sensitive to feedback, defensive behavior.	› Does not keep all appointments. › Not always respectfully. › Does not handle stress well, is insecure. › Open to feedback but doesn't handle feedback adequately. No initiative to receive feedback. › Shabby appearance	› Keeps appointments concerning work › Respectful to others. › Can identify stress and insecurities but cannot handle it without help. › Adequate handling of feedback › Appropriate appearance	› Keeps all appointments › Respectful to others. › Adequately handling stress and insecurities › Gives and receives feedback › Reflects on his own action. › Appropriate appearance	› Keeps all appointments › Respectful to others and tactful. › Adequately handling stress and insecurities. › Able to admit own mistakes. › Gives and receives feedback › Gives constructive feedback to others and can motivate them › Handles conflicts in a professional way › Corrects his behavior spontaneously › Health criticism.

Internal Medicine Logbook

Course Coordinator: _____

Group: _____ Date: _____

Internal medicine cases

1. Congestive heart failure
2. Chest Pain (including IHD/ACS), Arrhythmia: AF
3. Hypertension
4. Valvular heart disease/ rheumatic fever
5. ARF/CRF/ Haematuria/ proteinuria/ UTI
6. Glomerulonephritis/ Nephrotic syndrome
7. Electrolyte or acid/base disorder/
8. PUO/Sepsis, bacteraemia.
9. Infections: Brucellosis/Malaria/Tuberculosis/ Typhoid/Haemorrhagic fever: dengue fever AIDS, STD; CNS infection: Meningitis/Brain abscess, encephalitis.
10. Obstructive COPD (including acute exacerbation)/ Asthma
11. Pneumonia/Pulmonary embolus, thromboembolic disease
12. Acute respiratory failure/ haemoptysis, ARDS, sleep apnoea.
13. Suppurative lung diseases:(lung abscess, Bronchiectasis).
14. Pleural disorders (effusion, empyema, and pneumothorax).
15. Interstitial lung disease/ Lung fibrosis.
16. Anaemia (iron, haemolytic, megaloblastic), thrombocytopenia, pancytopenia.
17. Bleeding disorders, coagulopathy, and thrombotic disorders
18. Diabetes: DKA, hypoglycaemia, HNKC.
19. Endocrine: Thyroid Disease – Hypo/ hyperthyroidism, pituitary & adrenal disorders.
20. Peptic ulcer diseases/ Reflux esophagitis
21. Liver cirrhosis (G.I. Bleeding/ Jaundice/ Ascites)
22. Chronic diarrhoea IBS/IBD.
23. Polyarthritis (Rheumatoid arthritis/ SLE/ Scleroderma, vasculitis etc)
24. Monoarthritis (Crystal arthropathy, APS)
25. Stroke/TIA/ Syncope
26. Epilepsy/ Seizure Disorder
27. Altered mental status (Coma)
28. Headache.
29. Parkinson`s disease, movement disorders, MS, MND.
30. Paraplegia: Myopathies, spinal cord disorders, P neuropathy and NM diseases.

Patients' Case Log

No.	Clinical Condition	Number		Examiner Evaluation		Trainer's signature	Date
		Presented	Attended	History	Exam		
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Procedures

1. Vitals signs including Glasgow Coma Scale.
2. Pulse oximetry and O2 administration (methods & setup and devices).
3. Arterial puncture and ABG interpretation
4. Radiology: CXR, abdomen, skull film interpretation & basic interpretation CT, MRI
5. Lumbar puncture: Interpretation and Performance including CS fluid (observe, analysis)
6. ECG (performance and interpretation) and placement of cardiac monitor leads
7. Cardiac enzyme interpretation and Thrombolytic therapy
8. Safe handling of blood specimens, Blood culture techniques and Blood transfusion.
9. CBC & ESR interpretation
10. Coagulation profile interpretation: Bleeding time, PT, Aptt
11. Finger stick puncture technique and Blood sugar measurement
12. Insulin injection and Insulin pump technique
13. Diabetes test interpretation
14. Thyroid test interpretation
15. Basic Spirometry and peak flow
16. Inhalation therapy technique (delivery, space devices
17. Thoracocentesis/ Pleural tap/drainage and Pleural fluid examination.
18. Liver FT interpretation/ Ascitic tap and paracentesis technique/ Stool examination (
19. Urethral catheterisation/ Clean-catch urine technique/Urinalysis (dipstick & microscopic)
20. Renal function test interpretation/ Basic dialysis techniques

Level of trainee's participation in different procedures

Observation of the procedure O
Assistance in the procedure A
Performance of the Procedure (supervised) Ps
Performance of the procedure (independent) P

Procedures Log							
No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
			O	A	P		
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Academic Activities

Journal Club, Seminars, Tutorials, Conferences and Workshop

Academic activities					
No.	Topic	Activity	Presented "P" or attended "A"	Date	Trainer's signature
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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
3. Diagnosis
4. Plan
5. Communication

Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

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General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

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2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
3. Diagnosis
4. Plan
5. Communication

Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

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Evaluator's name: .....
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Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)
This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

1. insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors.

2. insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Final Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

1. insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors.

1. insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program

Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
Five Year	
Hospital manager signature	

Paediatrics Logbook

Course Coordinator: _____

Group: _____ Date: _____

Pediatrics cases

In general, you should average at least three patients per week. Thus, you will be able to evaluate 30 or more patients during a -12week pediatrics clerkship.

List of required cases for P1 /P2:

1. Congenital cardiac defects (Acyanotic/ Cyanotic)
2. Myocarditis / Infective endocarditis / Cardiomyopathy.
3. Acute rheumatic fever/ Kawasaki disease
4. Bronchial asthma.
5. Pneumonia (any type)
6. Bronchiolitis.
7. Croup /epiglottitis/ Foreign body aspiration.
8. Gastroenteritis/ Diarrhea.
9. Malabsorption syndrome/ Celiac disease.
10. Gastroesophageal reflux D/ pyloric stenosis.
11. Constipations, Hirschsprung disease.
12. Glomerulonephritis/ Nephrotic syndrome.
13. UTI & amp; Vesicoureteral reflux.
14. Anemia (Iron deficiency, Sickle cell anemia/Thalassemia/ G6PD).
15. ITP, Hemophilia, VWD.
16. Leukemia/ malignant disease.
19. HSP/ Juvenile idiopathic arthritis/ SLE/ Transient synovitis.
20. Encephalitis /meningitis/ Sepsis/ Cellulitis.
21. Common viral illness (Measles, mumps, EBV, Herpes Simplex, Varicella, Hepatitis).
22. Diabetes / Hypothyroidism/ Rickets/CAH/ Cushing Syndrome.
23. Epilepsy/febrile seizure.
24. Cerebral palsy /hypotonic infant/ Guillain-Barre syndrome/ Ataxias.
25. Microcephaly/ Macrocephaly.
26. Neonatal jaundice/ IDM/ Hypoxic-ischemic encephalopathy.
27. Syndromes (Trisomy 21/ any other syndrome).
28. RDS /meconium aspiration / Diaphragmatic hernia /TTN/ congenital pneumonia.
29. Paediatric poisoning/ Scorpion sting/ Allergies/ Immunodeficiency disorders.
30. Acute abdomen/ Liver disease / Pancreatic disease/ Gastritis.

Patients' Case Log

No.	Clinical Condition	Number		Examiner Evaluation		Trainer's signature	Date
		Presented	Attended	History	Exam		
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Procedures› Log

Level of trainee's participation in different procedures

1 Observation of the procedure O
2. Assistance in the procedure A
3. Performance of the Procedure (supervised) P

List of required procedures for P1 /P2:

1. Pulse oximetry: Oxygen saturation monitoring.
2. ABG interpretation.
3. CBC & ESR / blood biochemistry report interpretation.
4. Measure growth parameters and plot in appropriate charts
5. Measure Blood pressure and other vital signs
6. X-Ray interpretation.
7. ECG (performance and interpretation).
8. Intravenous and interosseous cannulation
9. Lumbar puncture
10. Measure blood sugar and using glucometer/ Insulin injection.
11. Vaccination in children (Vaccination practice at vaccine room).
12. Basic airway management Bag / mask ventilation.
13. Basic Spirometry and peak flow measurement
14. Inhalation therapy technique/ use of spacer devices.
15. Urine collection /Urinalysis (dipstick).

Journal Club, Seminars, Tutorials, Conferences and Workshop

Academic activities

No.	Topic	Activity	Presented "P" or attended "A"	Date	Trainer's signature
1					
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Academic Activities

Journal Club, Seminars, Tutorials, Conferences and Workshop

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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
3. Diagnosis
4. Plan
5. Communication

Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

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Location: Ward/ Outpatient/ ED Observed: Yes/ No

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What went well and why? Circle the domain

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What can be done better and why? Circle the domain

1. History taking
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4. Plan
5. Communication

Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
3. Diagnosis
4. Plan
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General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

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3. Diagnosis
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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

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Date: .....

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What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

Insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Final Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

Insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program

Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
Five Year	
Hospital manager signature	

Surgery Logbook

Course Coordinator: _____

Group: _____ Date: _____

Surgery cases

In general, you should average at least three patients per week. Thus, you will be able to evaluate 30 or more patients during a -12week Surgery clerkship.

Cases:

1. Breast lump
2. Diabetic foot
3. Acute abdomen
4. Appendicitis
5. Peptic ulcer disease
6. Thyroid swelling
7. Perforated viscus
8. Liver disease (Abscess/Cyst/ mass)
9. Pancreatic diseases (Pancreatitis/ meass)
10. Gallstones
11. Cholecystitis
12. Obstructive jaundice
13. Abdominal wall hernia (Inguinal, PUH, Incisional)
14. Lipoma/ swelling/cutaneous lesions
15. Colonic polyps/ mass
16. Colonic diverticular disease
17. Upper Gastrointestinal haemorrhage
18. Lower Gastrointestinal haemorrhage
19. Haemorrhoides
20. Perianal fistula
21. Bowel obstruction (Large-Small)
22. Gastric mass
23. Splenic disease
24. Cutaneous abscess
25. Wound infection
26. Breast neoplasm
27. Poly trauma
28. Postoperative complications
29. Burn
30. Adrenal disease

Patients' Case Log

No.	Clinical Condition	Number		Examiner Evaluation		Trainer's signature	Date
		Presented	Attended	History	Exam		
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Procedures› Log

Level of trainee's participation in different procedures

1 Observation of the procedure O
2. Assistance in the procedure A
3. Performance of the Procedure (supervised) P

Procedures: (Observe/do if applicable)

1. Appendectomy
2. Cholecystectomy
3. Insertion of nasogastric tube
4. Urinary catheterization
5. Incision and drainage of abscess
6. Excision of lipoma
7. Insertion of chest tube
8. Wound suturing
9. Removal of surgical drains
10. Fine needle aspiration FNA of lesion
11. Observe PR exam
12. Observe Proctoscopy and interpretation of findings
13. Colostomy care
14. Limb amputation
15. Hemorrhoidectomy

Procedures Log

No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
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Academic Activities

Journal Club, Seminars, Tutorials, Conferences and Workshop

Academic activities					
No.	Topic	Activity	Presented "P" or attended "A"	Date	Trainer's signature
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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

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Location: Ward/ Outpatient/ ED Observed: Yes/ No

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Assessment form On Call/ Duty

Date: .....

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General impression: Insufficient/ Sufficient/ Good /Excellent

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What went well and why?

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The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

Insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program

Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
Five Year	
Hospital manager signature	

Obstetrics and Gynecology Logbook

Course Coordinator: _____

Group: _____ Date: _____

Obstetrics & Gynecological cases

In general, you should average at least three patients per week. Thus, you will be able to evaluate 20-15 or more patients during a 6 week in Obstetrics and Gynecology clerkship

1.Normal pregnancy (Routine Antennal care)
2.Miscarriage case (any type)
3.Molar pregnancy
4.Ectopic pregnancy
5.VBAC. Vaginal Birth After C-section
6.Multiple pregnancy
7.Preterm labour
8.Placenta previa case
9.Abruptio placentae case.
10.Hypermisis gravidarum case
11.Diabetes with pregnancy
12.Hypertension with pregnancy
13.Infertility case
14.PCOS case
15.Fibroid case
16.post-menopausal case
17.Menorragia case
18.Fetal medicine case (any one)
19.Eclampsia and preeclampsia
20.Post-partum haemorrhage case

Procedures Log

No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
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Procedures› Log

Level of trainee's participation in different procedures

1 Observation of the procedure O
2. Assistance in the procedure A
3. Performance of the Procedure (supervised) Ps
4. Performance of the procedure (independent) P

Procedures

1. Vaginal delivery
2. Manual removal of placenta
3. Caesarean section
4. External cephalic version
5. Internal podalic version
6. Delivery of second twin
7. Evacuation and curettage
8. Suction evacuation
9. IUCD insertion
10. Impanon insertion
11. Shoulder dystocia monoverse
12. Forceps and ventose delivery
13. Abdominal ultrasound
14. Vaginal ultrasound
15. Vaginal swab
16. Speculum examination
17. Amniocentesis
18. Bimanual examination
19. Pap smear
20. Colposcopy or hysteroscopy
21. Hysterectomy
22. Myomectomy
23. Cystectomy

Procedures Log

No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
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Journal Club, Seminars, Tutorials, Conferences and Workshop

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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

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Medical problem: .....

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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

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Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

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Assessment form On Call/ Duty

Date: .....

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Assessment form On Call/ Duty

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Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

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Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program

Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
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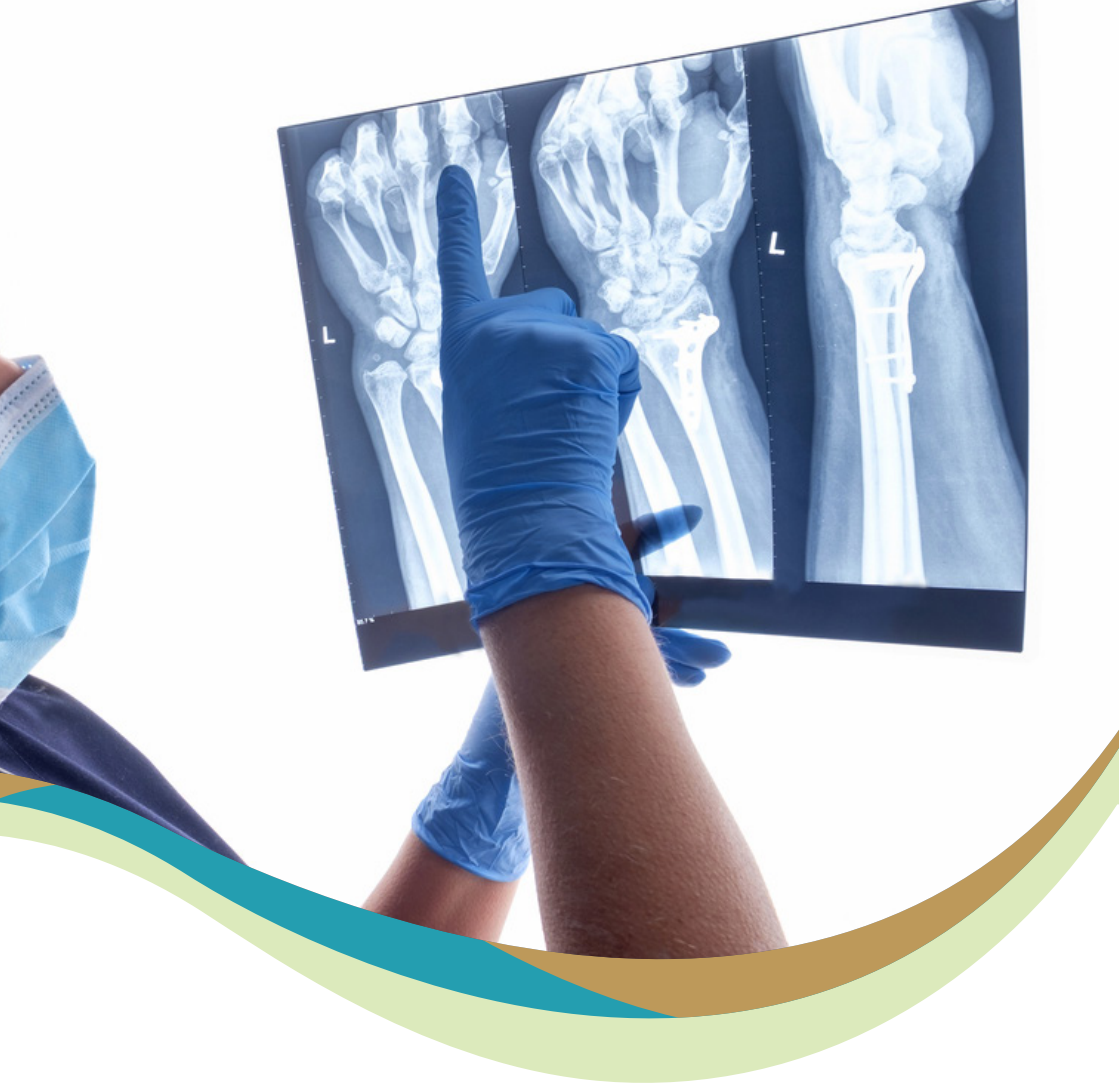
Hospital manager signature	



Orthopaedics Logbook

Course Coordinator: _____

Group: _____ Date: _____

Orthopedics cases

In general, you should average at least three patients per week. Thus, you will be able to evaluate 30-20 or more patients during a 6 –week in Orthopedics clerkship.

Congenital cases › DDH › Club foot › Degenerative joint disease (knee and hip)	**Dislocation of large joint** › Hip › Shoulder › Knee › Elbow › Perthes disease › Cases of cerebral palsy › Cases of Rickets	**Fracture of lower limb** › Neck of femur › Intertrochanteric fracture › Fracture femur › Fracture patella › Fracture tibia › Fracture tibial plateau › Ankle fracture › Talus and calcaneal fracture › Metatarsal bone fracture
Lower limp deformity › bow leg › physiological › Blount›s disease › Genu Varus › Genu valgus › Flat foot › Hallux valgus & Varus	**Fracture of upper limb** › Clavicle › Humorous › Supracondylar fracture › Ulna and radios › Scaphoid fracture › Mallet finger	**Bone and joint infection** › Acute OM › Chronic OM › Septic arthritis
Sport injury of the knee and ankle › ACL & collateral lig. injury › Meniscal torn › Sprain ankle › Orthosis and orthotic application	**Dislocation of large joint** › Osteosarcoma, Osteochondroma › bone cysts › Ewing sarcoma › Ostoidosteoma	› › Intervertebral disc lesion › Vertebral fracture; cervical and lumbar spine › Spine deformity; scoliosis, kyphosis › Spondylolisthesis and spondylolysis › Osteocalcin and osteoporosis

Those in italic are desirable to be recorded

Patients' Case Log

No.	Clinical Condition	Number		Examiner Evaluation		Trainer's signature	Date
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Procedures› Log

Level of trainee's participation in different procedures

1 Observation of the procedure O
2. Assistance in the procedure A
3. Performance of the Procedure (supervised) Ps
4. Performance of the procedure (independent) P

Procedures

1. Shoulder joint injection
    a. Glenohumeral joint
    b. Sub acromial space
    c. Biceps tendon
2. Elbow injection
    a. Tennis elbow
    b. Golfer elbow
3. Knee joint injection and aspiration
4. Cast application and removal
5. Traction
    a. Skeletal
    b. Skin traction

Procedures Log

No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
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1							
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Academic Activities

Journal Club, Seminars, Tutorials, Conferences and Workshop

Academic activities					
No.	Topic	Activity	Presented "P" or attended "A"	Date	Trainer's signature
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3					
4					
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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
3. Diagnosis
4. Plan
5. Communication

Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

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What can be done better and why?

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Date: .....

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Evaluator's name: .....
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Assessment form: Ward

Date: .....

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What went well and why?

What can be done better and why?

The student was present from..... Hour.

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

Insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program

Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
Five Year	
Hospital manager signature	

Emergency Medicine Logbook

Course Coordinator: _____

Group: _____ Date: _____

Emergency Medicine Cases

In general, you should average at least three patients per week. Thus, you will be able to evaluate 30-20 or more patients during a 6 -week Emergency Medicine clerkship

Gastroenterology & Hepatic Disorders

- Undifferentiated abdominal pain
- Upper and lower GIT bleeding
- Anal pain and rectal bleeding
- Diverticulitis
- Abdominal aortic aneurysm
- Sexually Transmitted Diseases
- Acute hepatitis
- Vomiting
- Faecal impaction
- Liver failure
- Acute cholecystitis &cholangitis

Cardiology

- ACS
- Arrhythmia
- Cardiac tamponade
- Hypertensive crisis
- Shock all varieties

Vascular Emergencies

- Limb ischaemia
- DVT

ED management

- Major Incident Management
- Concepts and application of triage
- Field to hospital communication and chain of command
- Leading teams and giving orders
- Basic concepts of debriefing and giving feedback
- Time flow management

Neurological Emergencies

- Acute stroke/ TIA
- Spinal cord lesions
- Peripheral neuropathies
- Acute mental status change
- Migraine
- Meningitis/encephalitis/brain abscess
- Vertigo

Respiratory Medicine

- Airway obstruction
- Haemoptysis
- Respiratory failure
- Pneumonia
- Asthma, COPD
- Restrictive airway disease
- Acute pneumothorax
- Pulmonary embolism

Initial management of the mechanically ventilated patient

Major Trauma

- Abdominal Trauma
- Chest Trauma
- Head Injury
- Spinal Injury
- Maxillo-facial Trauma
- Orthopedic Trauma
- Toxicology
- Treatment of acute ingestions
- Identification of basic toxidromes e.g. paracetamol poisoning.

EYE

- Acute conjunctivitis - bacterial and viral
- Acute vision loss
- Acute eye trauma including globe rupture

ENT

- Epistaxis
- Infections of the head &neck

Renal & Acid-Base Disorders

- Identification of acid-base disorders
- Fluid and Electrolytes
- Acute renal failure
- Acute urinary retention or bladder obstruction
- Nephrolithiasis and colic
- Dehydration
- Hyperkalemia, Hyponatremia

ED management

- Diabetic emergencies (DKA, hypoglycaemia,
- HONK, lactic acidosis
- Thyroid emergencies

Addison`s crisis

Dental Emergencies

- Dental abscess
- Dental fracture

Rheumatology &Immunology

- Crystal arthropathy
- Arthritis
- Immune disorders: SLE
- Anaphylaxis

ED management

- Blistering and exfoliative diseases
- Differential diagnosis of rash
- Erythroderma

Paediatric

- Child abuse signs and symptoms
- Neonatal emergencies
- Neonatal resuscitation
- Hyperbilirubinemia
- Disorders of feeding
- Neonatal fever
- Basic management of pediatric airway
- Basic pediatric resuscitation
- Common infectious diseases of childhood
- Fever in the first 6 months of life
- Common injury patterns for normal children

Haematology & Oncology

- Anemia
- Bleeding disorders
- Anticoagulant overuse.
- Thrombocytopenia
- Thrombotic disorders
- Acute leukemia
- Neutropenia and neutropenic fever
- Solid tumours
- Complications of chemotherapeutic agents

Psychiatry

- Acute psychosis
- Mood disorders
- Personality disorders
- Acute suicidal and homicidal ideation
- Substance abuse

Obs & Gynaecology

- Pelvic pain
- Dysfunctional uterine bleeding
- Ectopic pregnancy
- Uncomplicated emergency vaginal delivery

Infectious Diseases and Sepsis

- Sepsis
- Malaria, typhoid, brucellosis, dengue fever
- Common infectious diseases or conditions (e.g. pneumonia, UTI)
- Parasitic conditions and infestations.
- Cellulitis and gangrene

Environmental Emergencies

- Hyperthermia
- Hypothermia and frostbite
- Envenomation and environmental toxin exposure

Patients' Case Log

No.	Clinical Condition	Number		Examiner Evaluation		Trainer's signature	Date
		Presented	Attended	History	Exam		
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Procedures› Log

Urgent Care: ABC

- Basic airway management Bag/ /Laryngeal mask/ Mouth to mouth/mask ventilation
- Endotracheal intubation/ Rapid sequence induction
- Pulse oximetry: Oxygen saturation monitoring
- O2 administration (methods & setup).
- Oxygen concentrators, oximetry and devices and delivery
- Intravenous access
- Arterial puncture
- ABG interpretation
- CPR (External cardiac massage)
- Defibrillation/ DC cardioversion
- Pericardiocentesis
- Reduction of tension pneumothorax

Haematology

- Safe handling of blood specimens
- Technique for obtaining and making peripheral blood-smear
- CBC & ESR interpretation
- Bleeding time
- Prothrombin time (perform)
- Blood culture techniques
- Coagulopathy interpretation & mgmt
- Anaemia evaluation & mgmt.
- Blood transfusion
- Thrombolytic therapy
- Central vein cannulation
- Venous blood sampling

Body system: Respiratory

- Basic Spirometry and peak flow measurement
- use of spacer devices
- Use of medication delivery devices
- Inhalation therapy technique
- Thoracocentesis
- Pleural tap/drainage
- Pleural fluid examination.

Cardiac

- CXR: interpretation
- Placement of cardiac monitor leads
- ECG (performance and interpretation)
- Cardiac enzyme interpretation

Endocrine

- Finger stick puncture technique
- Blood sugar measurement
- Glucometer techniques
- Insulin injection
- Insulin pump technique
- Diabetes test interpretation
- Thyroid test interpretation

Urogenital

- Clean-catch urine technique
- Urinalysis (dipstick & microscopic)
- Abdominal plain film KUB interpretation
- Basic dialysis techniques
- Renal function test interpretation.
- Urethral catheterisation

Neurological

- Skull film interpretation
- CT, MRI basic interpretation
- Lumbar puncture: Interpretation and Performance
- CS fluid (observe, analyse)
- Nerve conduction velocity/EMG (indications, basic interpretation)
- EEG (indications, basic interpretation of results).
- Perform Glasgow Coma Scale

Gastrointestinal tract

- Stool examination (guaiac)
- Nasogastric intubation
- Paracentesis technique
- Liver FT interpretation
- Ascitic tap and paracentesis
- Abdominal plain x-ray interpretation
- Barium swallow interpret.
- Abdominal US/ CT interpret

Procedures› Log

Level of trainee's participation in different procedures

1 Observation of the procedure O
2. Assistance in the procedure A
3. Performance of the Procedure (supervised) Ps
4. Performance of the procedure (independent) P

Procedures Log

No.	Case Diagnosis	Procedure name	Number			Trainer's signature	Date
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Journal Club, Seminars, Tutorials, Conferences and Workshop

Academic activities					
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Assessment form Date: .....

Location: Ward/ Outpatient/ ED Observed: Yes/ No

Medical problem: .....

What went well and why? Circle the domain

1. History taking
2. Physical examination
3.Diagnosis
4.Plan
5. Communication

What can be done better and why? Circle the domain

1. History taking
2. Physical examination
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Professional behavior:

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Assessment form Date: .....

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Assessment form On Call/ Duty

Date: .....

Professional behaviour on duty:

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Professional behavior during the student's participation in the ward rounds:

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General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....
Signature: .....

Mid-Term Assessment by Coordinator

Date: .....

Full attendance Yes/No

Amount and variety of cases and reviews:

Insufficient (<5) / sufficient (8-5)/ good (12-9) /Excellent (>12 case)

This judgment can be adjusted depending on the quality of reviews.

Professional behavior with the patients

Insufficient/ sufficient/ good

Professional behavior with colleagues and supervisors

Insufficient/ sufficient/ good

Goods Points

Points to improve

Remarks

General impression: Insufficient/ Sufficient/ Good /Excellent

Evaluator's name: .....

Signature: .....

Rotation Proof during the program
Program Rotation map

Hospital manager signature after the end of the rotation and the signature must be stamped

Year of Training	Rotation
Fourth Year	
Hospital manager signature	
Five Year	
Hospital manager signature	

Administrative Guidelines of Clerkship

The Skeleton of The clerkship in the Pre-Graduate level is mainly composed of the following elements:

1- The Academic Affairs Department in the Hospitals :

Is the Administrative Body that represents the hospital (training centre) through-which all official contacts with the university take place. It is responsible for:

A. Contacting the departments in the hospital enquiring about preliminary acceptance of training and capacity.

B. Informing the University regarding available training slots for students in each discipline in the hospital within an assigned period.

C. Acquire detailed information about the required training sessions from the university in each discipline, which includes:

i. Number, level and gender of trainees

ii. Date of start and end of training for each group

iii. Days of training

D. Inform all Departments about the essential information regarding training.

E. Determine the prerequisites and procedures required from students before they can start training, and inform the university clerkship Coordinators of all prerequisites at least two weeks before the start of training.

F. Process the Starting procedures of the students and provide them with training IDs (maximally at Day 1 of the training period as long as all requirements are fulfilled).

G. The authority of stopping training for any reason belongs solely to the Academic Affairs Department.

2- Students

Students are usually divided into three groups

A. The Group Leader :

- Should be a student from the same group, agreed by most of the group members and by the course organizer, with no Registration problems in the University.
- Responsibilities include:

i. Being a link between the students and the clerkship coordinator, the training coordinator in the department, and the academic affairs secretary.

ii. Give a regular feedback to the clerkship coordinator about the quality and the efficacy of the training in the department.

iii. Arrange with the training coordinator in the department if needed regarding the distribution of the sub-groups and assigning a leader to each one.

iv. Collect the attendance sheets of the sub-groups and submit them to the secretary of the department and course organizer.

NOTES:

- Any Announcement or decision that reaches the group leader is considered as it reached all group members.
- The final decision of dividing the sub-groups, assigning their leader, distribution of sub-groups, or anything related to the clinical activity coordination is under the authority of the training coordinator in the department.
- Any fake signature for any student, or any change in the attendance sheet is under the responsibility of the group leader unless he/she reported the incident to the course organizer.
- Any comments or complaints related to the training should be submitted to the Clerkship Coordinator.
- At the end of each semester, the overall group leader can get a letter from the course organizer stating his/her role as a group leader (this does not apply to leaders of subgroups).

B. Regular Student:

- This includes all group members (Other than overall group leaders) who have no registration problems in the University.
- Responsibilities:

i. Fulfil all requirements and prerequisites for training and to obtain the hospital ID.

ii. Attend all academic activities that are assigned to them by the training coordinator in the department in the assigned time and place.

iii. Respect trainers, patients, colleagues, and all members at the health team.

iv. Abide by all regulations of the training centre.

v. Look, dress, and act professionally. (Unsuitable dress, haircut, accessories, etc. are unaccepted. Student dismissed from any activity due to such behaviour shall be considered absent).

NOTES:

- Any comments or suggestions regarding the clinical training should be relayed through the group leader who should raise the issue to the clerkship coordinator.
- All responsibilities of a regular student apply also to the group leader.
- If students believe that the leader should be changed, they must take permission from the course organizer regarding the substitution of him.

C.Student with Registration Problems:

- Students who are not officially registered to a course do not have the right to enter the hospital, see patients, sign the attendance sheets, receive any kind of clinical training, nor to participate in any type of clinical evaluation.
- To transfer such student form this category to the category of the regular student, an official notification should be delivered to the head of the clinical department, who in turn will inform the clerkship coordinator and the course organizer about the situation.
- Unregistered students take full responsibility for any consequences caused by the delay in registration in the course.

3- Training Coordinator in the Department :

- A training Coordinator is assigned by the hospital department to facilitate training.
- Responsibilities:

a- Dividing students into subgroups and assigning a leader to each in coordination with the group leader.

b- Prepare the clinical training timetable in the hospital, which should clarify the sessions, the trainer, the sub-group, the time of each session

c- Follow the academic clerkship guidelines for each discipline, assessing trainers and students.

d- Reports any issue or incident relating to training or students to the clerkship Coordinator, who in turn will raise it to the head of clinical department for further action.

e- Calculating the actual training hours of each trainer as well as the percentage of the amount of payment that will be given to each one.

4- The Secretary of the department in the Hospital :

- The department secretary is the main assistant of the training coordinator of the department.
- Responsibilities:

a- Arranging and typing the training schedule and attendance forms and distributing them according to the training schedule.

b- Communicates between the Clerkship Coordinator and the department in the hospital.

c- Collects and submits the attendance forms to the trainers of each subgroup and collects them back, organizing with the group leader.

5- Clerkship Coordinator :

- The Clerkship Coordinator represents the University in the hospitals.
- Responsibilities:

a-The main link between the University, the Hospital, and students.

b-Supervises the quality and efficacy of clinical training.

c-Coordinates the clinical exams in the hospitals (under the supervision of the course organizer).

d-Calculates payment due for trainers, coordinators, examiners, and case preparers in the clinical section.

e-Communicates regularly with the departments in the hospital (at least 1 week prior to the clinical training period) and creates a communication link between the training coordinator in the department and the students› group leader.

f-Receives any complaints or incident reports either from the students› group leader or from the Clinical Coordinator in the hospital, and raises them immediately to the course organizer and the Head of Department.

6- The Course Organizer :

- As the clinical clerkship is an integral part of the course curriculum, all academic responsibilities of the course organizer shall be applied. (e.g. supervising the clerkship of the course, uploading the attendance in the system, supervising the exams, marking the clinical exam sheets, processing the marks to be finalized and published, etc.)
- Other Responsibilities:

a. Designing the academic Clerkship Guidelines for the course, to be a reference to the Training Coordinator in the department.

b. Report and recommend to the Head of Department issues relating to conduction of the training.

c. Supervises selection of the students› group leader.

7- The Head of Department :

- Is the Head of all Course Organizers of the Clinical Department as well as the direct supervisor of the Clerkship Coordinators.
- Responsibilities:

a. Appoints course organizers and clinical coordinators.

b. Supervises duties and evaluates performance of all members of the Clinical department, course organizers, and staff.

c. Takes the final decision in case of any problem or any reported issue.


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