

# Locum Assessment Form

|  |  |
| --- | --- |
| **DOCTOR’S NAME** |  |
| **GMC NO** |  |
| **GRADE (this post)** |  |
| **SPECIALTY** |  |
| **HOSPITAL** |  |
| **PERIOD** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Please tick the appropriate boxes:*** | **ABOVE AVERAGE** | **AVERAGE** | **BELOW AVERAGE** | **UNACCEPTABLE** |
|  |  |  |  |  |
| 1. History Taking |  |  |  |  |
| 2. Physical Examination |  |  |  |  |
| 3. Investigations and Diagnosis |  |  |  |  |
| 4. Judgment and Patient Management |  |  |  |  |
| 5. Practical Skill |  |  |  |  |
| 6. Communication |  |  |  |  |
|  |  |  |  |  |
| 7. Basic Science |  |  |  |  |
| 8. Clinical |  |  |  |  |
|  |  |  |  |  |
| 9. Reliability |  |  |  |  |
| 10. Leadership and Initiative |  |  |  |  |
| 11. Administration |  |  |  |  |
| 12. Time Keeping |  |  |  |  |

**ATTITUDES**

***Does this Doctor have any training needs that you have identified?***

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**Comments by Reporting Doctor:**

**Name of reporting doctor (in capitals): ...**………………………………………..……….

**Signed** ……………………………………………….. **Date** ……………………………………

**STATEMENT BY LOCUM DOCTOR**

*I have seen the above Assessment Report and I agree/disagree\* with its contents. I have also seen the Guidance Notes on the completion of the Assessment Report.*

**Signed** ……………………………………………….. **Date** ……………………………………

**Name of locum (in capitals):** ………………………………………………………..……..…

**Statement by Locum Doctor *(if desired)***

*\*Please delete as appropriate*

**This assessment form should be forwarded to the Medical Staffing/ AMD and EMD.**