Feedback For Program Location:

Central Minnesota Foot and Ankle Associates By Dr. Schleichert in St. Cloud, MN

by *1* students on April 22nd, 2011

OCPM Student Program Evaluation Feedback Form

01. In surgery, did you ... :

a. Scrub-In?

Yes 100%
No - 0%

b. Glove & Gown?

Yes 100%
No - 0%

c. Act as Scrub Nurse?

Yes 100%
No - 0%

d. Retract or Assist in Surgical Field?

Yes 100%
No - 0%

e. Suture?

Yes 0%
No - 100%

f. Perform Skin-Skin Procedures?

Yes 100%
No - 0%

Program Requirements & Reccomendations

02. Please type in your answers to the questions below. (Note: 500 character maximum for each question)

a. What specific preparation should future students do prior to participating in this program?
   - NA
b. What instruments or materials were you required to bring?
   - None
c. What were your chief responsibilities on this program?
   - Be at various places.
d. What were the most valuable learning experiences of this program?
   - First hand experience with a private pratice podiatrist.
e. What aspects of this program need improvement and/or attention? Please make suggestions.
   - None

03. Which best describes the location of this practice or hospital site:

- Rural Area - 0%
- Small Town - 0%
- Small City - 0%
- Suburb - 100%
- Large City - 0%
- No Answer - 0%

Additional Costs & Activities

04. Please type in your answers to the questions below about activities and necessary items. (Note: 500 character maximum per question)

a. If there was free time on weekends from this program, what did you find to do?
   - Family friends.
b. If free housing was provided, please list where.
   - NA
c. If there was NO housing provided, please list where you stayed and the cost.
   - NA
d. Where free meals provided? Yes No If not, where did you eat and at what cost per week.
   - NA
e. Did you need a car for the program?
   - Yes
f. If you did need a car, how many miles a day did you drive?
   - 50
g. How much did the transportation to the program and back cost?
   - gas
h. Is there a residency program associated with this program?
   - No.
i. Did you experience any special problems at this program? If so, what were they?
   - No.

Hour & Patient Estimates

05. List the average number of hours you spent on the program each day of the week:

i. Monday

8AM

5PM hour(s).

ii. Tuesday

8AM

5PM hour(s).

iii. Wednesday

8AM

5PM hour(s).

iv. Thursday

8AM

5PM hour(s).

v. Friday

8AM

5PM hour(s).

vi. Saturday

0AM

0PM hour(s).

vii. Sunday

0AM

0PM hour(s).

06. Which hours and days of the week were spent participating in the following: (List all office sites and hospitals if applicable) ex. MTWTh 8a-3p, Sa 1-2pm, Su 10-11a

a. Office hours
    - All
b. Hospital Floors or Surgery hours
    - varied
c. Hospital Clinic hours
    - varied
d. Nursing Home hours
    - 0
e. Other hours
    - All

07. Please fill in the totals below.

a. Total number of patients seen by the end of the program:
— 300 Average Number of Patients seen by 1 students.
b. Total number of hours spent in program activities by the end of the program:
— 100 Average Total Hours spent by 1 students.

08. Please list any areas of concentration observed while attending this program?

- None.

09. Average number of patients per day, including hospital rounds:

a. Office: **— 20**
b. Hospital: **— 0**

10. Rate this program overall on a scale of one to ten. 10 is best:
— 10 out of 10 Average Rating of 1 students.

11. Would you reccomend this program?

Yes: — 100%
No: — 0%