

Feedback For Program Location:

Our Lady of Mercy Medical Center By Dr. Walter in Bronx, NY

by 1 students on April 20th, 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 0%

No - 100%

d. Retract or Assist in Surgical Field?

Yes 100%

No - 0%

e. Suture?

Yes 100%

No - 0%

f. Perform Skin-Skin Procedures?

Yes 0%

No - 100%

Program Requirements & Recommendations

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?
 - ◊ review trauma classifications
- b. What instruments or materials were you required to bring?
 - ◊ none
- c. What were your chief responsibilities on this program?
 - ◊ get supplies for morning rounds treat clinic patients assist in surgery
- d. What were the most valuable learning experiences of this program?
 - ◊ hands on surgical experience
- e. What aspects of this program need improvement and/or attention? Please make suggestions.
 - ◊ there was a lot of down time arrange to work with other services like vascular or orthopedics as well

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

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

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?
 - ◊ yes visit friends
- b. If free housing was provided, please list where.
 - ◊ none provided
- c. If there was NO housing provided, please list where you stayed and the cost.
 - ◊ with friends free
- d. Where free meals provided? Yes No If not, where did you eat and at what cost per week.
 - ◊ yes
- 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?
 - ◊ 20
- g. How much did the transportation to the program and back cost?
 - ◊ 400.00
- h. Is there a residency program associated with this program?
 - ◊ yes
- i. Did you experience any special problems at this program? If so, what were they?
 - ◊ yes director needs to be informed what the hospital requires as far as qualifications and health records

Hour & Patient Estimates

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

- i. Monday
 - 5AM
 - 4PM hour(s).
- ii. Tuesday
 - 5AM
 - 4PM hour(s).
- iii. Wednesday
 - 5AM
 - 4PM hour(s).
- iv. Thursday
 - 5AM
 - 4PM hour(s).
- v. Friday
 - 5AM
 - 4PM 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
 - ◊ NA
- b. Hospital Floors or Surgery hours
 - ◊ mon-fri 7-9am
- c. Hospital Clinic hours
 - ◊ mon 9am-12pm wed 9am-12pm fri 1-4pm
- d. Nursing Home hours
 - ◊ NA
- e. Other hours
 - ◊ NA

07. Please fill in the totals below.

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

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

- surgery

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

- a. Office: — **0**
- b. Hospital: — **5**

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

11. Would you recommend this program?

Yes: — 0%
No: — 100%