Log Book

For 3rd Year MBBS

For Recording Practical And Clinical Activities

Department of Medical Education
Khyber Medical College Peshawar

About the student

Name of the student:

Father`s name:

Class:

Year of induction into KMC

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

Contents

Dean`s Message

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments at different times. Similarly, exposing the students to different clinical activities during undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of these events is important for student evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it is considered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Khyber Medical College is introducing the LOG BOOK for students of 3rd year and beyond to help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectives assigned, and will help the faculty in assessing student`s performance. The logbook system will be converted to a portfolio system in future.

Dean

Khyber Medical College

Peshawar

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence during assessment of student and evaluation of the overall performance of institution and curriculum. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Director Medical Education

Khyber Medical College

Objectives of clinical rotations

Clinical rotation is one of the integral parts of undergraduate medical students that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum. The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, patient management skills, team work, time management skills, and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record of history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All the students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co-curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment marks that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status

Level B: Assistant status

Level C: Performed part of the procedure under supervision

Level D: Performed whole procedure under supervision

Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient safety is not endangered. Students of 4th and 5th year are required to achieve level C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that you recognise that you bring valuable knowledge to every experience. It helps you therefore to recognise and clarify the important connections between what you already know and what you are learning. It is a way of helping you to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 3rd year, the MBBS students are rotated in following departments in groups of about 15 students:

1) Medicine
2) Surgery
3) Gynaecology
4) Pediatrics
5) Ophthalmology
6) ENT
7) Forensic Medicine
8) Cardiology
9) Pulmonology
10) Nephrology
11) Skills laboratory

In the next sections, a list of competencies, level of achievement, professionalism attributes and supervisor`s observations / approval with dates are mentioned.

General Medicine

Medical A unit

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:						
		• Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases 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)	
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

Medical B unit

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:						
		Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases 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)	
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

Medical C unit

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:						
		• Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases 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)	
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

Medical D unit

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:						
		• Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases 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)	
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

General Surgery

Surgical A unit

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)	
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

Surgical B unit

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)	
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

Surgical C unit

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)	
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

Surgical D unit

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)	
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

Gynecology and Obstetrics

Gynae A unit

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)	
Case Based Discussion (CBD)		
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

Gynae B unit

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)	
Case Based Discussion (CBD)		
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

Gynae C

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)	
Case Based Discussion (CBD)		
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

Pediatrics

Pediatrics A unit

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						
		• Mental state						
		• Capillary refill time						
		• Palpation of lymph nodes						
		• Others						
3		Growth parameters						
		• Height / length						
		• Weight						
		• Head circumference						
		• Use of centile charts						
		• Role play / counseling session						
		• Surgical hand washings						
		• Venipuncture / blood sampling / Injections						
		• Mantoux test						
		• Nebulization						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
History taking- presentation	Presented by:	
Vaccination schedules (EPI)	Presented by:	
Growth parameters	Presented by:	
Integrated management of neonatal and childhood illnesses (IMNCI)	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)	
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

Pediatrics B unit

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						
		• Dehydration status						
		• Others (specify)						
3		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:	
Vaccination schedules (EPI)	Presented by:	
Growth parameters	Presented by:	
Integrated management of neonatal and childhood illnesses (IMNCI)	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)	
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

Ophthalmology

Eye A unit

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 Eye unit						
2		General physical examination						
		• Visual acuity						
		• Examination of adnexa and anterior segment						
		• Ocular movements						
		• Pupillary reflexes						
		• Intraocular pressure						
		• Ophthalmoscopy						
		• Confrontation test for field of vision						
		• Slit lamp examination						
3		Procedures						
		• Irrigation of eye						
		• Instillation of eye drops						
		• Staining of corneal ulcer						
		• Removal of superficial foreign bodies						
		• Rational use of topical anesthesia						
		• Other (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases in ophthalmology	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)	
Field visit	Details:	
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

Eye B unit

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 Eye unit						
2		General physical examination						
		• Visual acuity						
		• Examination of adnexa and anterior segment						
		• Ocular movements						
		• Pupillary reflexes						
		• Intraocular pressure						
		• Ophthalmoscopy						
		• Confrontation test for field of vision						
		• Slit lamp examination						
3		Procedures						
		• Irrigation of eye						
		• Instillation of eye drops						
		• Staining of corneal ulcer						
		• Removal of superficial foreign bodies						
		• Rational use of topical anesthesia						
		• Other (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases in ophthalmology	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)	
Field visit	Details:	
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

Otorhinolaryngology

ENT A unit

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 ENT unit						
2		Complete regional examination						
		• Ear						
		• Nose						
		• Throat						
		• Draining Lymph nodes						
		• Examination of cranial nerves						
		• Others (specify)						
3		Skills						
		• Use of head mirror						
		• Examination of oropharynx						
		• Use the tongue blade						
		• Use of nasal speculum						
		• Indirect laryngoscopy						
		• Nasopharyngoscopy						
		• Demonstrate the use of otoscope						
		• Demonstrate the use of tuning fork						
		• Other (specify)						
4		Anterior nasal packing						
5		Ear suction / syringing						
6		Antral wash-out						
7		tonsillectomy						
		Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases in ENT	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)	
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

ENT B unit

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 ENT unit						
2		Complete regional examination						
		• Ear						
		• Nose						
		• Throat						
		• Draining Lymph nodes						
		• Examination of cranial nerves						
		• Others (specify)						
3		Skills						
		• Use of head mirror						
		• Examination of oropharynx						
		• Use the tongue blade						
		• Use of nasal speculum						
		• Indirect laryngoscopy						
		• Nasopharyngoscopy						
		• Demonstrate the use of otoscope						
		• Demonstrate the use of tuning fork						
		• Other (specify)						
4		Anterior nasal packing						
5		Ear suction / syringing						
6		Antral wash-out						
7		tonsillectomy						
		Others (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases in ENT	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)	
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

Forensic Medicine

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		• Medicolegal examination of an injured						
		• Examination for age						
		• Examination of forensic radiology						
		• Examination of sexual assault victim						
		• Others (specify)						
2		Procedure for						
		• Taking consent and Medical certification						
		• For preservation and dispatch of biological material						
		• Identification of poisons						
		• Other (specify)						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Field visits	By: 1) 2) 3)	
List of autopsies	1) 2) 3)	
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				
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

Skills laboratory

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		IV line insertion						
2		Nasogastric tube insertion						
3		Foley`s catheter insertion						
4		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						
5		CPR						
6		Endotracheal intubation						
7		Others						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to skill lab.	Presented by:	
BCLS workshop	Conducted by:	
Normal vaginal delivery		
Other activities		
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 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

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 (date)	Signature of organizer / incharge

*Student can paste the proof / certificate / office order of the activities / events

For student affairs / 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: 50**		
	%age							

Deputy / Controller of examination

Sign_____

Director Medical Education

Sign_____