MEDICAL UNIVERSITY OF SOUTH CAROLINA
Office of Graduate Medical Education

END-OF- PROGRAM FINAL EVALUATION OF RESIDENT/FELLOW

Name: _____

Residency Program: _____

Period of Training: _____to_____

This document will certify that the above named individual was evaluated by the residency program faculty during this specified period of training sponsored by the Medical University of South Carolina.

These evaluations document that Dr. _____ has satisfactorily completed the requirements of the ACGME-approved residency program and has demonstrated sufficient competence to enter practice without direct supervision in the specialty of _____.

Special Comments or Commendations:

Awards or Honors:

Residency Program Director: _____

Date: _____