New York College of Osteopathic Medicine

Learning Outcomes Assessment 2009-2010

January 2009

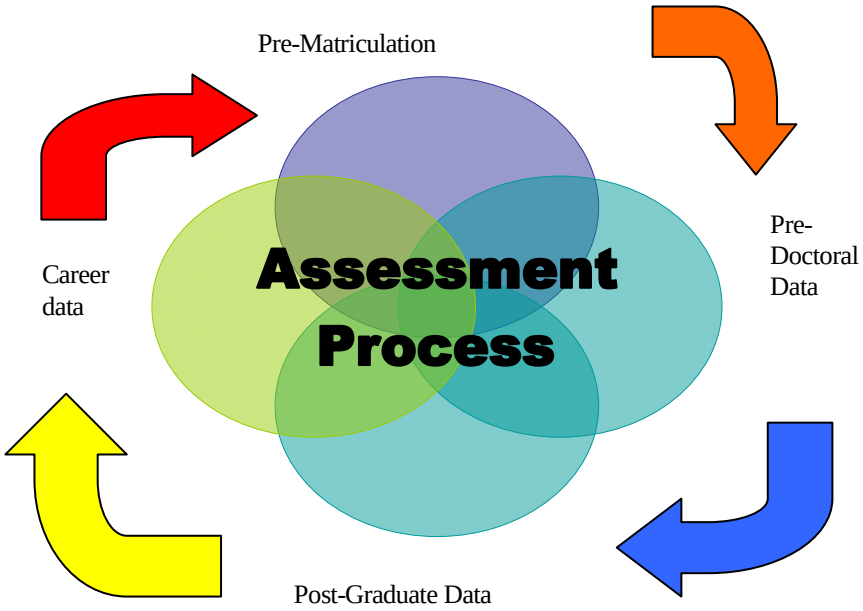

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Table of Contents

List of Tables and Figures

New York College of Osteopathic Medicine
Learning Outcomes Assessment Plan

February 2009

Overview

This document was developed by the NYCOM Task Force on Learning Outcomes Assessment and was accepted by the dean in January 2009. Although a few of the assessment tools and processes described in the document are new, most have been employed at NYCOM since its inception to inform curriculum design and implementation and to gauge progress and success in meeting the institution's mission, goals and objectives.

The Learning Outcomes Assessment Plan documents the processes and measures used by the institution to gauge student achievement and program (curricular) effectiveness. The results of these activities are used by faculty to devise ways to improve student learning and by administrators and other stakeholder groups to assess institutional effectiveness and inform planning, decision-making, and resource allocation.

Certain of the measures described in later sections of this document constitute key performance indicators for the institution, for which numerical goals have been set. Performance on these measures has a significant effect on institutional planning and decision-making regarding areas of investment and growth, program improvement, and policy.

Key performance indicators and benchmarks are summarized below and also on page 151 of the plan.

Indicator Benchmarks	
• Number of Applicants	Maintain relative standing among Osteopathic Medical Colleges
• Admissions Profile	Maintain or improve current admissions profile based on academic criteria (MCAT, GPA, Colleges attended
• Attrition	3% or less
• Remediation rate (preclinical)	2% reduction per year
• COMLEX USA scores (first-time pass rates, mean scores)	Top quartile
• Students entering OGME	Maintain or improve OGME placement
• Graduates entering Primary Care careers	Maintain or improve Primary Care placement
• Career characteristics	Regarding Licensure, Board Certification, Geographic Practice, and Scholarly achievements--TBD

I. Introduction and Rationale

At NYCOM we believe it is our societal responsibility to monitor our students' quality of education through continual assessment of educational outcomes. On-going program evaluation mandates longitudinal study (repeated observations over time) and the utilization of empirical data based on a scientific methodology.

At Thomas Jefferson University, an innovative study was implemented circa 1970, which was ultimately titled "*Jefferson Longitudinal Study of Medical Education*".[1] As a result of implementation of this longitudinal study plan, Thomas Jefferson University was praised by the

[1] Center for Research in Medical Education and Health Care: Jefferson Longitudinal Study of Medical Education, Thomas Jefferson University, 2005.

Accreditation Team for the Middle States Commission on Higher Education for "…..their academic interest in outcome data, responsiveness to faculty and department needs and the clear use of data to modify the curriculum and teaching environment….their use of this data has impacted many components of the curriculum, the learning environment, individual student development, and program planning…" (TJU, 2005).

The Jefferson Longitudinal Study of Medical Education has been the most productive longitudinal study of medical students and graduates of a single medical school. This study has resulted in 155 publications in peer review journals. Many were presented before national or international professional meetings prior to their publication (TJU, 2005).

According to Hernon and Dugan (2004), the pressure on higher education institutions to prove accountability has moved beyond the acceptance and reliance of self-reports and anecdotal evidence compiled during the self-regulatory accreditation process. It now encompasses an increasing demand from a variety of constituencies to demonstrate institutional effectiveness by focusing on quality measures, such as educational quality, and cost efficiencies.

Accountability focuses on results as institutions quantify or provide evidence that they are meeting their stated mission, goals, and objectives. Institutional effectiveness is concerned, in part, with measuring (Hernon and Dugan, 2004):

- Programmatic outcomes: such as applicant pool, retention rates, and graduation rates. Such outcomes are institution-based and may be used to compare internal year-to-year institutional performance and as comparative measures with other institutions.

- Student learning outcomes: oftentimes referred to as educational quality and concerned with attributes and abilities, both cognitive and affective, which reflect how student experiences at the institution supported their development as individuals. Students are expected to demonstrate acquisition of specific knowledge and skills.

At NYCOM, we recognize that our effectiveness as an institution must ultimately be assessed and expressed by evaluating our success in achieving our Mission in relation to the following Outcomes:

1. Student Learning / Program Effectiveness
2. Research and Scholarly Output
3. Clinical Services

The present document focuses on #1, above, viz., Student Learning / Program Effectiveness. That is, it is intended only as a Learning Outcomes Assessment Plan. At the same time, we are cognizant that Institutional Effectiveness/Outcomes derive from numerous inputs, or "means" to these "ends," including:

1. Finances
2. Faculty Resources
3. Administrative Resources
4. Student Support Services
5. Clinical Facilities and Resources
6. Characteristics of the Physical Plant
7. Information Technology Resources
8. Library Resources

We believe it is our obligation to continually assess the impact of any changes in the inputs, processes, and outputs of this institution.

The evaluation approach in this Assessment Plan provides for on-going data collection and analysis targeted specifically at assessing outcomes of student achievement and program effectiveness (educational quality). Assessment of achievement and program effectiveness is based on objective, quantifiable information (data).

As a result of the NYCOM Learning Outcome Assessment Plan's continual assessment cycle, the report is available, with scheduled updates, as a resource in the decision-making process.

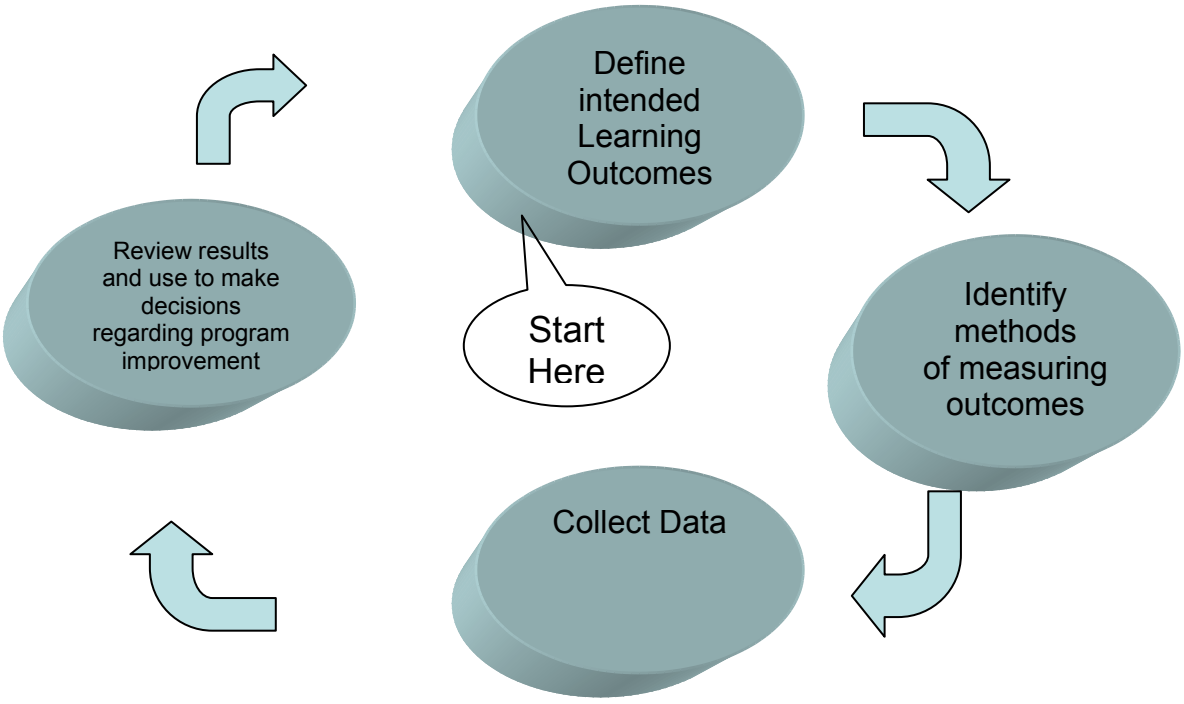
The report provides outcomes data, recommendations, and suggestions intended to inform key policy makers and stakeholders[2] of areas of growth and/or improvement, together with proposed changes to policy that strengthen both overall assessment and data-driven efforts to improve student learning.

[2] NYCOM Administration, academic committees, faculty, potential researchers, and students.

II. Purpose and Design

Well-designed plans for assessing student learning outcomes link learning outcomes, measures, data analysis, and action planning in a continuous cycle of improvement illustrated below.

Figure 1 Cycle of Assessment



Ten principles guide the specifics of NYCOM's Learning Outcomes Assessment Plan:

1. The plan provides formative and summative assessment of student learning.[3]
2. The primary purpose for assessing outcomes is to improve student learning.
3. Developing and revising an assessment plan is a long-term, dynamic, and collaborative process.
4. Assessments use the most reliable and valid instruments available.

[3] Examples of the former include post-course roundtable discussions, Institute for Clinical Competence (ICC) seminars, and data from the Course/Faculty Assessment Program. Examples of the latter include the AACOM Graduation Questionnaire, COMLEX scores, NBOME subject exam scores, and clerkship evaluations.

5. Assessment priorities are grounded in NYCOM's mission, goals, and learning outcomes.
6. The assessment involves a multi-method approach.
7. Assessment of student learning is separate from evaluation of faculty.
8. The primary benefit of assessment is the provision of evidence-based analysis to inform decision-making concerning program revision and improvement and resource allocation.
9. The assessment plan must provide a substantive and sustainable mechanism for fulfilling NYCOM's responsibility to ensure the quality, rigor, and overall effectiveness of our programs in educating competent and compassionate physicians.
10. The assessment plan yields valid measures of student outcomes that provide stakeholders with relevant and timely data to make informed decisions on changes in curricular design, implementation, program planning, and the overall learning environment.

Outcomes assessment is a continuous process of measuring institutional effectiveness focusing on planning, determining, understanding, and improving student learning. At NYCOM, we are mindful that an integral component of this assessment plan is to ensure that the plan and the reporting process measures what it is intended to measure (student achievement and program effectiveness).

III. Specifics of the Plan

The NYCOM assessment plan articulates eleven student learning outcomes, which are linked to both the institutional mission and the osteopathic core competencies

Mission of NYCOM

The New York College of Osteopathic Medicine of the New York Institute of Technology is committed to training osteopathic physicians for a lifetime of learning and practice, based upon the integration of evidence-based knowledge, critical thinking and the tenets of osteopathic principles and practice. The college is also committed to preparing osteopathic physicians for careers in primary care, including health care in the inner city and rural communities, as well as to the scholarly pursuit of new knowledge concerning health and disease. NYCOM provides a continuum of educational experiences to its students, extending through the clinical and post-graduate years of training. This continuum provides the future osteopathic physician with the foundation necessary to maintain competence and compassion, as well as the ability to better serve society through research, teaching, and leadership.

Learning Outcomes

The following eleven (11) Learning Outcomes that guide this plan stem from NYCOM's mission (above) and the osteopathic core competencies:

1. The Osteopathic Philosophy: Upon graduation, a student must possess the ability to demonstrate the basic knowledge of Osteopathic philosophy and practice, as well as Osteopathic Manipulative Treatment.
2. Medical Knowledge: A student must possess the ability to demonstrate medical knowledge through passing of course tests, standardized tests of the NBOME, post-

course rotation tests, research activities, presentations, and participation in directed reading programs and/or journal clubs, and/or other evidence-based medicine activities.

3. Practice-based learning and improvement: Students must demonstrate their ability to critically evaluate their methods of clinical practice, integrate evidence-based medicine into patient care, show an understanding of research methods, and improve patient care practices
4. Professionalism: Students must demonstrate knowledge of professional, ethical, legal, practice management, and public health issues applicable to medical practice.
5. Systems-based practice: Students must demonstrate an understanding of health care delivery systems, provide effective patient care and practice cost-effective medicine within the system.
6. Patient Care: Students must demonstrate the ability to effectively treat patients and provide medical care which incorporates the osteopathic philosophy, empathy, preventive medicine education, and health promotion.
7. Communication skills: Students must demonstrate interpersonal and communication skills with patients and other healthcare professionals, which enable them to establish and maintain professional relationships with patients, families, and other healthcare providers.
8. Primary Care: Students will be prepared for careers in primary care, including health care in the inner city, as well as rural communities.
9. Scholarly/Research Activities: Students will be prepared for the scholarly pursuit of new knowledge concerning health and disease. Students in NYCOM's 5-year Academic Medicine Scholars Program will be prepared as academic physicians in order to address

this nation's projected health care provider shortage and the resulting expansion of medical school training facilities.

10. Global Medicine and Health policy: Students will be prepared to engage in global health practice, policy, and the development of solutions to the world's vital health problems.

11. Cultural Competence: Students will be prepared to deliver the highest quality medical care, with the highest degree of compassion, understanding, and empathy toward cultural differences in our global society.

The NYCOM assessment plan provides for analysis of learning outcomes for two curricular tracks and four categories of student

NYCOM has historically tracked student data across the curriculum, paying particular attention to cohorts of students (see below), as well as NYCOM's two curricular tracks:

a) Lecture-Based Discussion track: integrates the biomedical and clinical sciences along continuous didactic 'threads' delivered according to a systems based approach;
b) Doctor Patient Continuum track: a problem-based curriculum, whose cornerstone is small-group, case-based learning.

Current data gathering incorporates tracking outcomes associated with several subcategories of student (important to the institution) within the 4-year pre-doctoral curriculum and the 5-year pre-doctoral Academic Medicine Scholars curriculum. The pre-doctoral populations are defined according to the following subcategories:

- *Traditional*:[4]
- *BS/DO:* The BS/DO program is a combined baccalaureate/doctor of osteopathic medicine program requiring successful completion of a total of 7 years (undergraduate, 3 years; osteopathic medical school, 4 years).
- *MedPrep*: A pre-matriculation program offering academic enrichment to facilitate the acceptance of underrepresented minority and economically disadvantaged student applicants.[5]

[4] All other students not inclusive of *BS/DO, MedPrep, and EPP* defined cohorts.
[5] The program is funded by the New York State Collegiate Science and Technology Entry Program and the NYCOM Office of Equity and Opportunity Programs.

- *EPP (Émigré Physician Program):* A 4-year program, offered by NYCOM, to educate émigré physicians to become DOs to enable them to continue their professional careers in the U.S.

The NYCOM assessment plan includes data from four phases of the medical education continuum (as illustrated in Figure 2 and Figure 3): pre-matriculation, the four-year pre-doctoral curriculum[6], post-graduation data, and careers and practice data

Within the NYCOM Learning Outcome Assessment Plan, the Task Force has chosen the following outcome indicators for assessment of program effectiveness at different points in the medical education continuum:

- Pre-matriculation data, including first-year student survey;
- Academic (pre-clinical) course-work (scores on exams, etc.) – attrition rate;
- Clinical Clerkship Evaluations (3^{rd}/4^{th} year) and NBOME Subject Exams;
- Student feedback (assessment) of courses and 3^{rd} and 4^{th} year clinical clerkships and PDA-based Patient and Educational Activity Tracking;
- COMLEX USA Level I, Level II CE & PE, and Level III data, including:
    - First-time and overall pass rates and mean scores;
    - Comparison of NYCOM first time and overall pass rates and mean scores to national rankings;
- Residency match rate and placement rate (AOA / NRMP);
- Feedback from AACOM Graduation Questionnaire;
- Completion rates of Post-Doctoral programs;
- Specialty certification and licensure;
- Career choices (practice type--academic, research, etc.);
- Geographic practice locations;
- Alumni survey.

The Outcome Indicators—Detail sections of this plan (pages 24 through 150) show the various data sources and include copies of the forms or survey questionnaires utilized in the data gathering process.

The NYCOM assessment plan identifies specific sources of data for each phase

Figure 2 illustrates which of the above measures are most relevant at each phase of the medical education continuum.

[6] And the five-year pre-doctoral Academic Medicine Scholars program

Figure 2

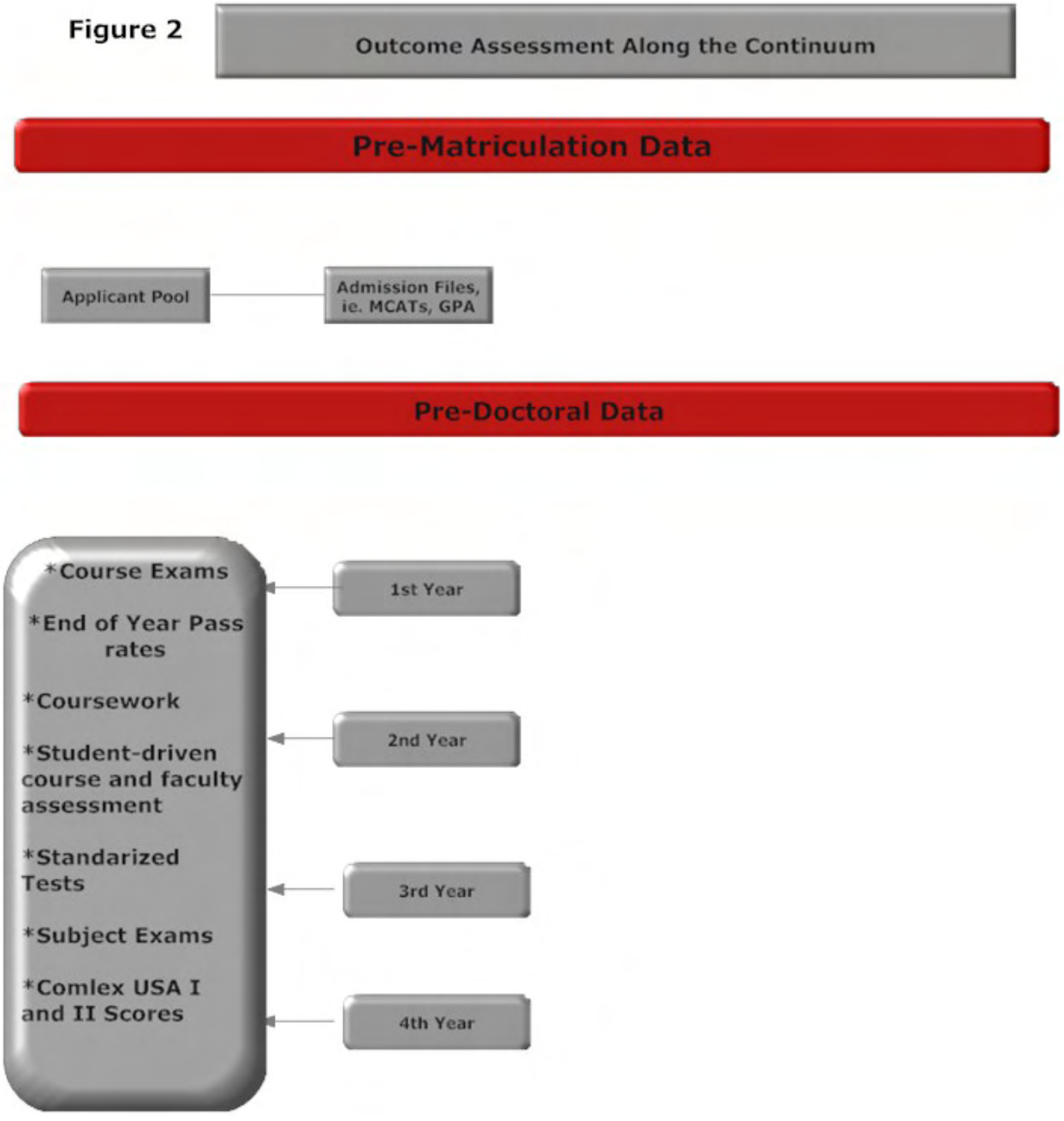
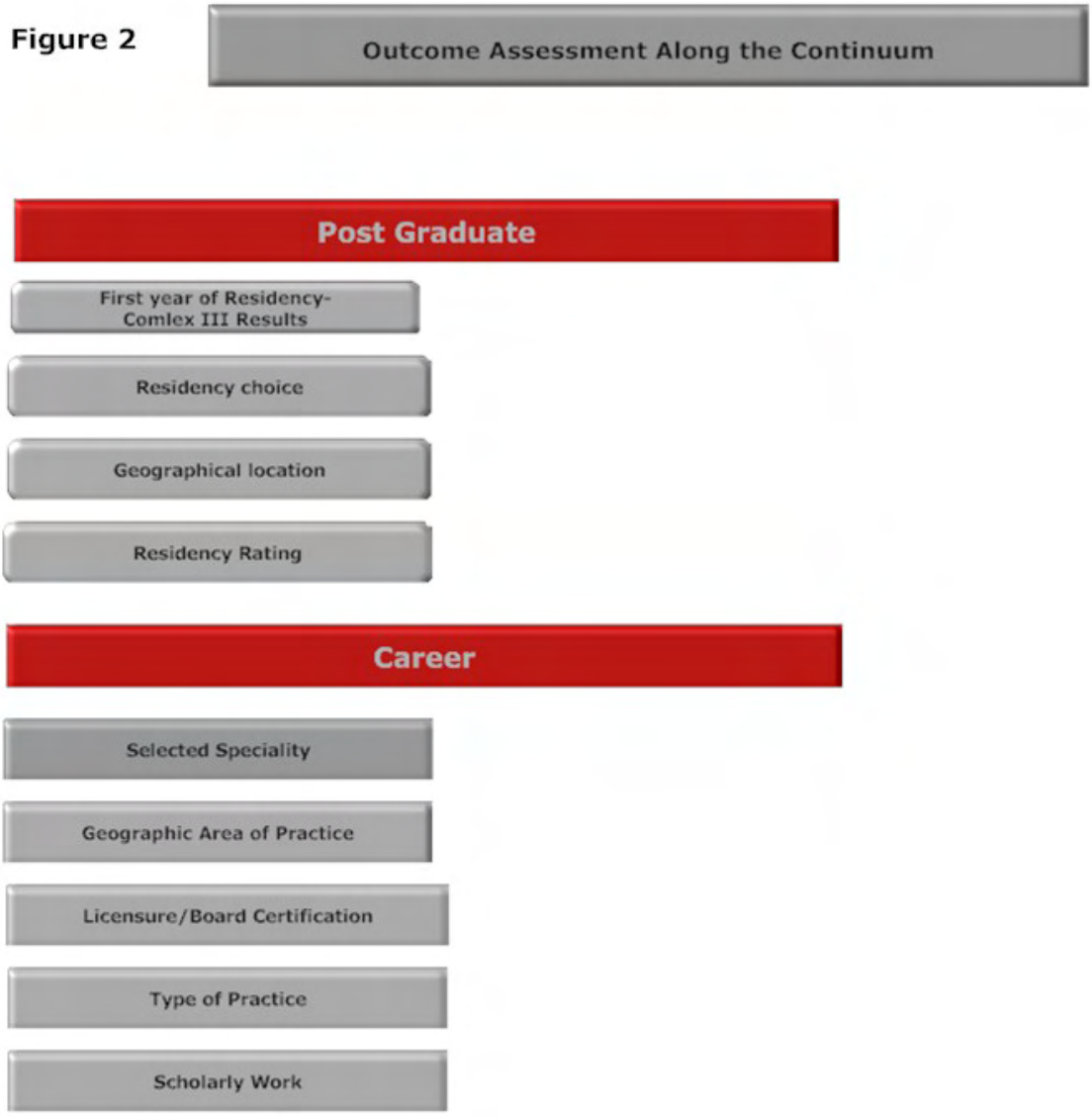

Outcome Assessment Along the Continuum
Pre-Matriculation Data
Applicant Pool
Admission Files, ie. MCATs, GPA
Pre-Doctoral Data
*Course Exams
*End of Year Pass rates
*Coursework
*Student-driven course and faculty assessment
*Standarized Tests
*Subject Exams
*Comlex USA I and II Scores
1st Year
2nd Year
3rd Year
4th Year

Figure 2


Outcome Assessment Along the Continuum
Post Graduate
First year of Residency- Comlex III Results
Residency choice
Geographical location
Residency Rating
Career
Selected Speciality
Geographic Area of Practice
Licensure/Board Certification
Type of Practice
Scholarly Work

The NYCOM assessment plan describes the collection and reporting of data, responsibilities for analysis and dissemination, and the linkage to continuous program improvement and institutional planning

Compiling the Data

Discussions with departmental leaders and deans confirmed that data gathering occurs at various levels throughout the institution. Development of a central repository (centralized database) facilitates data gathering, data mining and overall efficiency as it relates to data analysis, report generation, and report dissemination. This includes utilization of internal databases (internal to NYCOM) as well as interfacing with external organizations' databases, including the AOA (American Osteopathic Association), AACOM (American Association of Colleges of Osteopathic Medicine), AMA (American Medical Association), and the ABMS (American Board of Medical Specialties).

Stakeholders

Information from the data collection serves to inform NYCOM administration, relevant faculty, appropriate research and academic/administrative committees, including the following:

- Curriculum Committee
- Student Progress Committee
- Admissions Committee
- Deans and Chairs Committee
- Clinical and Basic Science Chairs
- Research Advisory Group
- Academic Senate

The NYCOM assessment plan sets forth benchmarks, goals and standards of performance

The major elements of the plan are summarized in Table 1: **Assessment Plan Guide: Learning Outcomes/Metrics/Benchmarks** found at the end of this chapter.

IV. Plan Implementation

As discussed earlier, most of the assessment tools and processes described in the document have been employed at NYCOM since its inception to inform curriculum design and implementation and to gauge progress and success in meeting the institution's mission, goals and objectives. Beginning in fall 2008, however, assessment efforts have been made more systematic; policies, procedures, and accountabilities are now documented and more widely disseminated.

The **Office of Program Evaluation and Assessment** (OPEA), reporting to the Associate Dean for Academic Affairs is responsible for directing all aspects of plan refinement and implementation.

Next steps

1. **Develop a shared, central repository for pre-matriculation, pre-doctoral, and post-graduate data (see Figure 3). Time Frame: Academic Year 2010-2011**

Centralized database: Development of a (shared or **central) repository (database)** utilized by internal departments of NYCOM. *WEAVEonline* is a web-bases assessment system, utilized by numerous academic institutions across the country, for assessment and planning purposes. Utilizing this program facilitates centralization of data. The central database is comprised of student data categorized as follows:

Pre-matriculation — Data includes demographics, AACOM pre-matriculation survey, academic data (GPA), and other admissions data (MCAT's, etc.).

Data is categorized according to student cohort as previously written and described (see item *III. Specifics of the Plan* on pages 13-14).

Pre-doctoral — Data includes academic (pre-clinical) course work, course grades, end-of-year grade point averages, the newly implemented, innovative Course / Faculty assessment program data (described in Section 4), ratings of clinical clerkship performance, performance scores on COMLEX USA Level I and Level II CE & PE, descriptors of changes in academic status (attrition), and AACOM Graduation questionnaires.

Post-graduate/Career — Data includes residency match rate, residency choice, hospitals of residency, geographic location, chosen specialty, performance on COMLEX Level III, geographic and specialty area(s) of practice following graduation, licensure, board certification status, scholarly work, professional activities/societies, faculty appointments, type(s) of practice (academic, clinical, research).

This database supports and assimilates collaborative surveys utilized by internal departments in order to capture requested data (see item *III. Specifics of the Plan* on pages 13-14) essential for tracking students during and after post-graduate training. Specific data (e.g., COMLEX Level III, board certification, and licensure) is provided by external databases, through periodic reporting means, or queries from NYCOM, therefore the database provides for assimilation of this external data, in order to incorporate into institutional reporting format.

2. Establish metrics. Time Frame: Academic Year 2010-2011

Benchmarks and Reporting: Conduct a retrospective data analysis in order to establish baseline metrics (see *Compiling the Data* on page 17).

Following development of these metrics, institutional benchmarks are established. Benchmarks align with Institutional Goals as written above.

Reporting of data analysis occurs on an annual basis. An annual performance report is compiled from all survey data and external sources. Timeframe for reporting is congruent with end of academic year. Updates to report occur semi-annually, as additional (external) data is received.

Data reporting includes benchmarking against Institutional Goals (mission), in order to provide projections around effectiveness of learning environment, quality improvement indicators, long-range and strategic planning processes, and cost analysis/budgetary considerations.

Report dissemination to key policy makers and stakeholders, as previously identified (see *Stakeholders* on page 17*)* in addition to other staff, as deemed appropriate for inclusion in the reporting of assessment analysis.

V. Conclusion

The impact on student learning of such things as changes in the demographics of medical school applicants, admissions criteria, curricula, priorities, and methods of delivery of medical education deserve careful discussion, planning, and analysis before, during, and after implementation. This plan facilitates change management at three points:

- **Planning,** by providing evidence to support decision-making;
- **Implementation,** by establishing mechanisms for setting performance targets and monitoring results, and

- **Evaluation,** by systematically measuring outcomes against goals and providing evidence of whether the change has achieved its intended objectives.

At NYCOM, accountability is seen as both a requirement and a responsibility. As healthcare delivery, pedagogy, and the science of medicine constantly change, monitoring the rigor and effectiveness of the learning environment through assessment of student learning outcomes throughout the medical education continuum becomes paramount.

Figure 3 Data Collection Phases

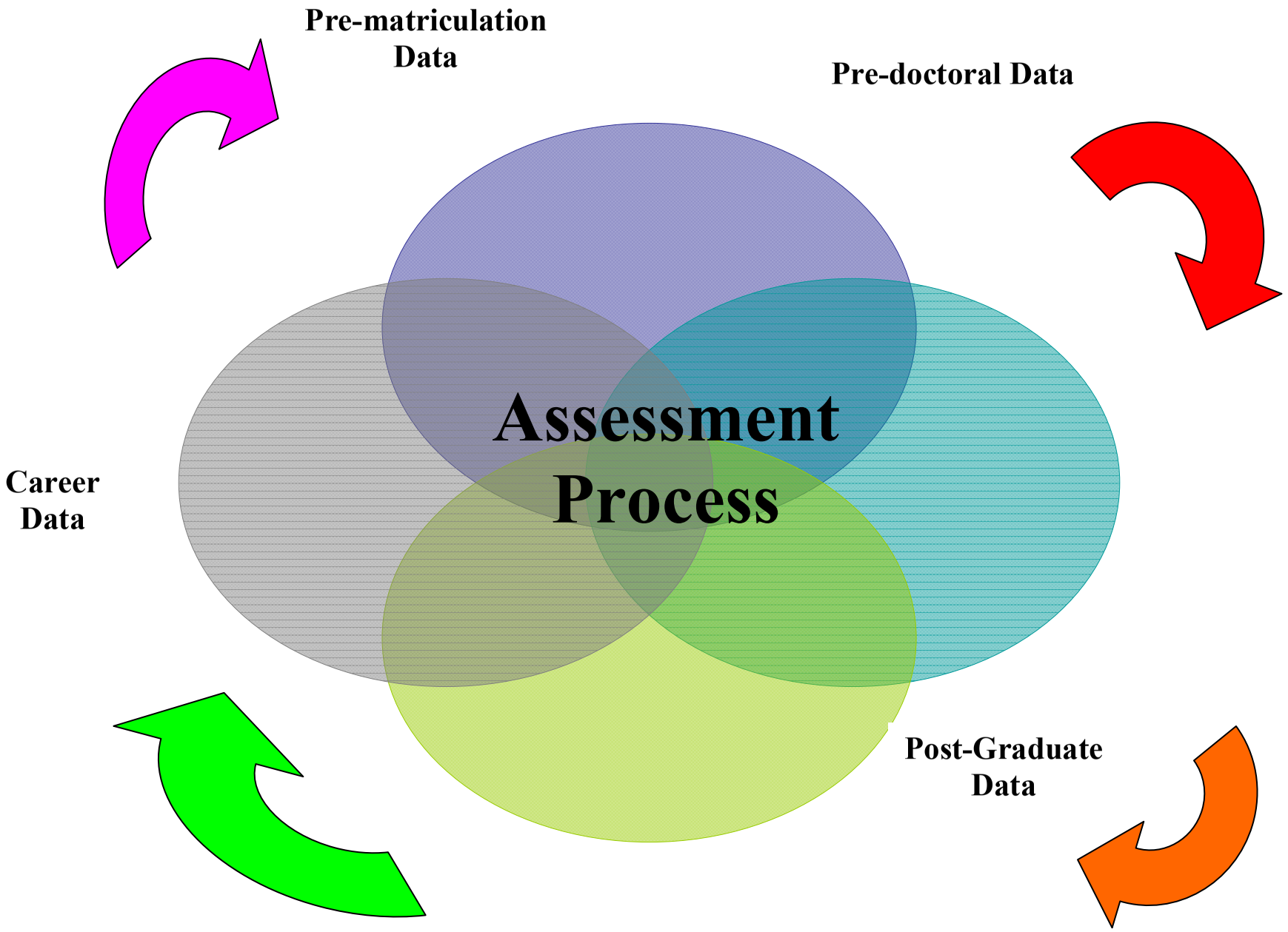


Table 1 – Assessment Plan Guide: Learning Outcomes / Data Sources / Metrics

Learning Outcomes[7]	Data Collection Phases[8]	Assessment Methods	Metrics[9]	Development of benchmarks[10]

Students will:
Demonstrate basic knowledge of OPP & OMT
Demonstrate medical knowledge
Demonstrate competency in practice-based learning and improvement
Demonstrate professionalism and ethical practice
Demonstrate an understanding of health care delivery systems
Demonstrate the ability to effectively treat patients
Demonstrate interpersonal and communication skills
Be prepared for careers in primary care
Be prepared for the scholarly pursuit of new knowledge
Be prepared to engage in global health practice, policy, and solutions to world health problems
Be prepared to effectively interact with people of diverse cultures and deliver the highest quality of medical care
	• Pre-matriculation
	• Pre-doctoral
	• Post-graduate
	• Career
		• Didactic Academic Performance
		  • LDB Curriculum
		  • DPC Curriculum
		• Formative / Summative Experiences: Patient Simulations (SP's / Robotic)
		• Student-driven Course, Clerkship, and Faculty Assessment
		• Clinical Clerkship Performance
		• PDA-Based Patient and Education Tracking
		• Surveys
		• Standardized Tests
		• Alumni Feedback
			Vis a Vis:
			• Admissions Data (Applicant Pool demographics)
			• Course Exams
			• End-of-year pass rates
			• Coursework
			• Analysis of Residency Trends Data
			• Standardized Tests Subject Exams
			• COMLEX 1 & II Scores
			• Analysis of Specialty Choice
			• Analysis of geographic practice area
			• Academic Attrition rates
			• Remediation rates
			• Graduation and post-graduate data
			• External surveys
				• Applicant Pool
				• Admissions Profile
				• Academic Attrition rates
				• Remediation rates (pre-clinical years)
				• COMLEX USA Scores I & II (1st time pass rate / mean score)
				• Number of graduates entering OGME programs
				• Graduates entering Primary Care (PC)[11]
				• Career Data:
				Licensure (within 3 years);
				Board Certification;
				Geographic Practice Area;
				Scholarly achievements

[7] Complete detail of Learning Outcomes found in **III., pages 11-13.**
[8] See **Figure 3, page 22**.
[9] List of Metrics is not all-inclusive.
[10] See complete detail of benchmarks—**pages 5 & 151.**
[11] Primary Care: Family Medicine, Internal Medicine, and Pediatrics.

Outcome Indicators – Detail

1. Pre-matriculation data

Data gathered prior to students entering NYCOM, and broken down by student cohort, which includes the following:

Traditional, MedPrep, and BS/DO students

- ✓ AACOM pre-matriculation survey given to students;
- ✓ Total MCAT scores;
- ✓ Collegiate GPA (total GPA-including undergraduate/graduate);
- ✓ Science GPA;
- ✓ College(s) attended;
- ✓ Undergraduate degree (and graduate degree, if applicable;
- ✓ Gender,;
- ✓ Age;
- ✓ Ethnicity;
- ✓ State of residence;
- ✓ Pre-admission interview score.

Additional data is gathered on the MedPrep student cohort and incorporates the following:

- ✓ Pre-matriculation lecture based exam and quiz scores;
- ✓ Pre-matriculation DPC (Doctor Patient Continuum) based facilitator assessment scores and content exam scores;

- ✓ ICC (Institute for Clinical Competence) Professional Assessment Rating (PARS) Scores.

Émigré Physician Program students

- ✓ TOEFL (Test of English as a Foreign Language) score;
- ✓ EPP Pre-Matriculation Examination score;
- ✓ Medical school attended;
- ✓ Date of MD degree;
- ✓ Age;
- ✓ Ethnicity;
- ✓ Country of Origin.

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- MedPrep 2008 Program Assessment
- MedPrep Grade Table
- NYCOM Admissions Interview Evaluation Form
- Application for Émigré Physicians Program (EPP)
- AACOM Pre-matriculation survey (first-year students)
- NYCOM Interview Evaluation Form – Émigré Physicians Program

Samples of the forms/questionnaires follow

MedPrep 2008 Program Assessment

Successful completion of the MedPrep Pre-Matriculation Program takes into consideration the following 3 assessment components:

1. **Lecture-Discussion Based (LDB)**
2. **DPC (Doctor Patient Continuum)**
3. **ICC (Institute for Clinical Competence)**

A successful candidate must achieve a passing score for all 3 components. Strength in one area will not compensate for weakness in another.

1. The first component assesses the **Lecture-Discussion Based** portion of the MedPrep Pre-Matriculation Program. It is comprised of 3 multiple choice quizzes and 1 multiple choice exam.

- Histology
- Biochemistry
- Physiology
- Genetics
- Physiology
- OMM
- Pharmacology
- Pathology
- Microbiology
- Clinical Reasoning Skills

Each of the three quizzes constitutes 10% of an individuals overall LDB score and the final exam (to be conducted on June 27) constitutes 70% of an individuals overall LDB score (comprising 100%) in the Lecture-Discussion portion of the program.

2. The second is based upon your performance in the **DPC** portion of the MedPrep Pre-Matriculation Program. There will be a facilitator assessment (to be conducted on June 26), which will comprise 30% of an individual's grade and a final written assessment which will be 70% of an individual's overall DPC score.

**** Note - Both the Lecture-Discussion Based and DPC passing scores are calculated as per NYCOM practice:**

- Average (mean) minus one standard deviation
- Not to be lower than 65%
- Not to be higher than 70%

3. The third component is the **ICC** encounter designed to assess your Doctor Patient Interpersonal skills. This assessment is evaluated on the PARS scale described to you in the Doctor Patient Interpersonal Skills session on June 12, by Dr. Errichetti.

After the program ends, on June 27th, all three components of the assessment will be compiled and reviewed by the MedPrep Committee. The director of admissions, who is a member of the committee, will prepare notification letters that will be mailed to you within two weeks.

Please note:

The written communication you will receive ONLY contains acceptance information. NO grades will be distributed. Exams or other assessments (with the exception of the Lecture-Discussion Based quizzes, which have already been returned) will not be shared or returned.

Please DO NOT contact anyone at NYCOM requesting the status of your candidacy. No information will be given on the phone or to students on campus.

Thank you for your participation in the MedPrep Pre-Marticulation Program. The faculty and staff have been delighted to meet and work with you. We wish you success!

Sincerely,

Bonnie Granat

Last Name, First Name	Quiz #1 Score (10% of Overall LDB Score)	Quiz #2 Score (10% of Overall LDB Score)	Quiz #3 Score (10% of Overall LDB Score)	LDB Final Exam Score (70% of Overall LDB Score)	Overall LBD Score (Exam and Quizzes Combined)	Overall DPC Score	Overall ICC Score

NEW YORK COLLEGE OF OSTEOPAHTIC MEDICINE
ADMISSIONS INTERVIEW EVALUATION FORM

Applicant_____ Date____/_____/____

CATEGORY	CRITERIA	VALUE	RATING
I. PERSONAL PRESENTATION	MATURITY LIFE EXPERIENCE /TRAVEL EXTRA CURRICULAR ACTIVITIES/HOBBIES COMMUNICATION SKILLS SELF ASSESSMENT (STRENGTHS/WEAKNESSES) AACOMAS & SUPPLEMENTAL STATEMENT	**50**	
II. OSTEOPATHIC MOTIVATION	KNOWLEDGE OF THE PROFESSION TALKED TO A DO/LETTER FROM A DO	**15**	
III. PRIMARY CARE MOTIVATION	INTEREST IN PRIMARY CARE	**15**	
IV. OVERALL IMPRESSION	EXPOSURE TO MEDICINE - VOLUNTEER EXPERIENCE - EMPLOYMENT EXPERIENCE - UNIQUE ACADEMIC EXPERIENCES - RESEARCH	**20**	
	TOTAL RATING	**100**	

INTERVIEWER:
Print
Name_____

Signed_____

OTHER COMMENTS: PLEASE USE OTHER SIDE (REQUIRED)

Comments on Applicant _____

COMMENTS:

Interviewer_____

APPLICATION FOR ÉMIGRÉ PHYSICIANS PROGRAM (EPP)

Application Deadline: March 16, 2009

1. SSN _____ 2. Name _____
Last First

3. Do you have educational materials under another name? Yes ( ) No ( ) If yes, indicate name_____

4. Have you previously applied? Yes ( ) No ( ) Year(s): _____

5. Preferred Mailing Address_____
Street Apt. #

_____ Telephone (_____)_____
City State Zip code Area code Number

E-mail: _____

6. Permanent and/or Legal Residence_____
Street Apt. #

_____ Telephone _(_____) _____
City State Zip code Area code Number

7. Year you emigrated to the United States

NOTE: Only U.S. Citizens or Permanent Residents are eligible.**
(Attach copy of citizenship papers/green card, front and back)
(APPLICANTS MUST BE IN POSSESSION OF "GREEN CARD" AT TIME OF APPLICATION)**

8. Are you a U.S. citizen? Yes ( ) No ( )

9. Are you a Permanent Resident? Yes ( ) No ( ) Year Green Card issued _____Green Card No._____

10. Sex: Male ( ) Female ( )

1 1 . Date of Birth: / / / /_____11 a. Place of Birth (city, country) _____
M D Y

12. How do you describe yourself? Black_____ Mex. Amer/Chicano _____ Asian/Pac.Isl. _____
White _____ Other Hispanic _____

13. Please list the members of your household:

Name,	Relationship to you (e.g. spouse, child, etc.),	Age
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

14. List all Colleges attended (Undergraduate, Graduate, Professional - US and Home Country) List in chronological order

Institution Name	Location	Dates of Attendance	Major Subject	Degree granted or expected (Date)

Medical Specialty (if any)_____ No. of years in practice _____

15. Have you had any U.S. military experience ? Yes ( ) No ( )

If yes, was your discharge honorable? Yes ( ) No ( )

16. List employment in chronological order, beginning with your current position:

Title or Description	Where	Dates	Level of Responsibility

17. Work/daytime telephone number_____
area code phone

18. How do you plan to finance your NYCOM education? Personal funds _____ Loans

19. Were you ever the recipient of any action for unacceptable academic performance or conduct violations (e.g. probation, dismissal, suspension, disqualification, etc.) by any college or school? Yes ( ) No( )
If yes, were you ever denied readmission? Yes ( ) No)

20. Have you ever been convicted of a misdemeanor or felony (excluding parking violations)? Yes ( ) No(
If your answer to #19 or #20 is yes, please explain fully:

21. Evaluation Service used: Globe Language Services _____ Joseph Silny & Assocs. _____
World Education Services _____ IERF _____

*22. TOEFL Score(s): _____

***ALL CANDIDATES MUST TAKE TOEFL / TOEFL**
Scores Cannot Be Older Than 2 YEARS

If you plan to take or retake the TOEFL, enter date: _____/_____/ mo.
yr .

(NYCOM's TOEFL Code is #2486; copies cannot be accepted)

USMLE WILL NOT BE ACCEPTED IN LIEU OF TOEFL

All evaluations must be received **directly** from the evaluation service and are subject to approval by the New York College of Osteopathic Medicine.

Personal Comments: Please discuss your reasons for applying to the EPP program.

Selection of candidates is competitive; achieving a minimum, passing TOEFL Score does not automatically guarantee an interview.

I certify that all information submitted in support of my application is complete and correct to the best of my knowledge.

Date: Signature: _____

PLEASE MAIL APPLICATION AND FEE ($60.00 CHECK OR MONEY ORDER ONLY, PAYABLE TO NYCOM) TO:

New York College of Osteopathic Medicine
Of New York Institute of Technology
Office of Admissions/ Serota Academic Center Room 203
Northern Blvd.
Old Westbury, NY 11568-8000

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE
2008-09 Academic Year Survey – First Year Students

***TO THE STUDENTS:* Your opinions and attitudes about your medical education, your plans for medical practice, and information about your debt are very important as the colleges and the osteopathic profession develop and plan for the future of osteopathic medical education. Please take some time to complete the following questionnaire to help in planning the future of osteopathic medical education. The information you provide in this survey will be reported only in aggregate or summary form; individually identifiable information will not be made available to the colleges or other organizations. The reason we ask for your identification is to allow for longitudinal studies linking your responses as first year students to your responses when this survey is readministered again in your fourth year.**

Please fill in marks like this:

Please print in Capital Letters:

Last Name _ Suffix _ _ _

First Name _ _ _ _ _ _ _ _ _ _ _ _ _ Middle Name _ _ _ _ _ _ _ _ _ _ _ _ _

or Maiden Name if Married Woman Using Husband's Name

Osteopathic College

O ATSU-SOMA	O LECOM-Bradenton	O OU-COM	O TUNCOM
O ATSU/KCOM	O LECOM-PA	O PCOM	O UMDNJ-SOM
O AZCOM	O LMU-DCOM	O PCSOM	O UNECOM
O CCOM	O MSUCOM	O PNWU-COM	O UNTHSC/TCOM
O DMU-COM	O NSU-COM	O RVUCOM	O VCOM
O GA-PCOM	O NYCOM	O TOUROCOM	O WesternU/COMP
O KCUMB-COM	O OSU-COM	O TUCOM-CA	O WVSOM

Part I: CAREER PLANS

P1. Plans Upon Graduation: Please indicate what type of osteopathic internship you plan to do. (Choose only one.)

O a. Traditional rotating

O b. Special emphasis — Indicate type:
- 1. Anesthesiology O
- 2. Diagnostic Radiology O
- 3. Emergency Med. O
- 4. Family Practice O
- 5. General Surgery O
- 6. Psychiatry O
- 7. Pathology O

O c. Specialty track — Indicate type:
- 1. Internal Medicine O
- 2. Internal Medicine/Peds. O
- 3. Ob/Gyn O
- 4. Otolaryn./Facial Plastic Surg. O
- 5. Pediatrics O
- 6. Urological Surgery O

O d. Pursue AOA/ACGME dual approved internship

O e. Not planning osteopathic internship. Reason:
- 1. Allopathic residency O
- 2. Other O

Please specify ______________________

O f. Undecided

P2. a. Immediate Post-Internship Residency Plans: Select the ***one*** item that best describes your plans immediately after internship *(or upon graduation if not planning an osteopathic internship).*

O 1. Pursue osteopathic residency
O 2. Pursue allopathic residency **(see Item P2b)**
O 3. Pursue AOA/ACGME dual approved residency **(see Item P2b)**
O 4. Enter governmental service (*e.g.,* military, NHS Corps, Indian Health Service, V.A., state/local health dept.) **(see Item P2b)**

If you are not doing a residency, please indicate your post-internship plans.

O 5. Practice in an HMO
O 6. Self-employed with or without a partner
O 7. Employed in group or other type of private practice (salary, commission, percentage)
O 8. Other professional activity (*e.g.,* teaching, research, administration, fellowship)
O 9. Undecided or indefinite post-graduation/internship plans

b. If you plan to pursue an allopathic or AOA/ACGME dual approved residency, please give *all* the reasons that apply to you.

O 1. Desire specialty training not available in osteopathic program
O 2. Believe better training and educational opportunities available
O 3. Located in more suitable geographic location(s)
O 4. Located in larger institutions
O 5. Better chance of being accepted in program
O 6. Allow ABMS Board certification
O 7. Opens more career opportunities
O 8. Military or government service obligation
O 9. Shorter training period
O 10. Higher pay
O 11. Other, please specify _____

P3. Long-Range Plans: Select the ***one*** item that best describes your intended activity five years ***after*** internship and residency training.

O 1. Enter governmental service (*e.g.,* military, NHS Corps, Indian Health Service, V.A., state/local health dept.)
O 2. Practice in an HMO
O 3. Self-employed with or without a partner
O 4. Employed in group or other type of private practice (salary, commission, percentage)
O 5. Other professional activity (*e.g.,* teaching, research, administration, fellowship)
O 6. Undecided or indefinite

P4. a. Area of Interest: Select *one* specialty in which you are most likely to work or seek training.

O 1. Family Practice
O 2. General Internal Medicine
O 3. Internal Medicine Subspecialty
O 4. Osteopathic Manip. Ther. & Neuromusculoskeletal Med.
O 5. General Pediatrics
O 6. Pediatrics Subspecialty
O 7. Allergy and Immunology
O 8. Anesthesiology
O 9. Critical Care
O 10. Dermatology
O 11. Emergency Medicine
O 12. Geriatrics
O 13. Medical Genetics
O 14. Neurology including subspecialties
O 15. Psychiatry including subspecialties
O 16. Nuclear Medicine
O 17. Ob/Gyn including subspecialties
O 18. Ophthalmology
O 19. Otolaryngology
O 20. Pathology including subspecialties
O 21. Physical Medicine & Rehabilitation Med.
O 22. Preventive Medicine including subspec.
O 23. Proctology
O 24. Radiology (Diagnostic) including subspec.
O 25. Sports Medicine
O 26. General Surgery
O 27. Orthopedic Surgery
O 28. Surgery, subspecialty
O 29. Vascular Surgery
O 30. Urology/Urological Surgery
O 31. Undecided or Indefinite

P4b. Please select *one* item that best describes your plans for board certification.

- O 1. AOA Boards (osteopathic)
- O 2. ABMS Boards (allopathic) **(see Item P4c)**
- O 3. Both boards **(see Item P4c)**
- O 4. Other, please specify _____
- O 5. Not planning board certification
- O 6. Undecided or indefinite

c. If you selected ABMS or both boards in item P4b, please indicate *all* the reasons for your choice.

- O 1. ABMS board certification is more widely recognized
- O 2. ABMS board certification has more colleague acceptance
- O 3. ABMS board certification carries more prestige
- O 4. ABMS board certification provides more opportunities (career, residencies, etc.)
- O 5. Personal desire for dual certification
- O 6. Hospital privileges more readily obtained with ABMS board certification.
- O 7. Licenses more readily obtained with ABMS board certification
- O 8. Other, please specify

_____

P5. Please indicate the importance of each of the following factors affecting your specialty choice decision. Use the scale below.

(1) Major Influence (2) Strong Influence (3) Moderate Influence (4) Minor Influence (5) No Influence/NA

a.	Intellectual content of the specialty (type of work, diagnostic programs, diversity)	① ② ③ ④ ⑤
b.	Like dealing with people (type of person, type of patient) more than techniques	① ② ③ ④ ⑤
c.	Prestige/income potential	① ② ③ ④ ⑤
d.	Lifestyle (predictable working hours, sufficient time for family)	① ② ③ ④ ⑤
e.	Like the emphasis on technical skills	① ② ③ ④ ⑤
f.	Role models (*e.g.*, physicians in the specialty)	① ② ③ ④ ⑤
g.	Peer influence (encouragement from practicing physicians, faculty, or other students)	① ② ③ ④ ⑤
h.	Skills/abilities (possess the skills required for the specialty or its patient population)	① ② ③ ④ ⑤
i.	Debt level (level of debt, length of residency, high malpractice insurance premiums)	① ② ③ ④ ⑤
j.	Academic environment (courses, clerkships in the specialty area)	① ② ③ ④ ⑤
k.	Opportunity for research/creativity	① ② ③ ④ ⑤
l.	Desire for independence	① ② ③ ④ ⑤
m.	Previous experience	① ② ③ ④ ⑤

P6. Answer only ONE item.

a. State (two-letter abbreviation) where you expect to locate after completion of internship and residency?

b. Fill in if non-U.S. O

c. Fill in if unknown/undecided O

P7. a. What is the population of the city/town/area of legal residence where you plan to be employed or in practice after completion of internship or residency?

1. Major metropolitan area (1,000,001 or more) O
2. Metropolitan area (500,001 – 1,000,000) O
3. City (100,001 – 500,000) O
4. City (50,001 – 100,000) O
5. City or town (10,001 – 50,000) O
6. City or town (2,501 – 10,000) O
7. Town under 2,500 O
8. Other, please specify O

_____

9. Undecided or indefinite O

b. Are you planning to practice in any underserved or shortage areas? Yes O No O Unsure O

P8. Expected Income: What annual net income do you expect to earn before taxes during:

a. First year in practice after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

b. Fifth year after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

c. Tenth year after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

Part II: Financial Aid

A1. Undergraduate College Debt: If none, enter zero.

a. **At entry** how much did you owe from undergraduate college or other postgraduate education?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

b. How much do you **expect to** owe on undergraduate college or other postgraduate education debt in **A1a** at graduation? (Exclude osteopathic medical school debt; that is covered in **A2**.)

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

A2. Osteopathic Medical School Indebtedness: Indicate the principal amount you expect to borrow from each loan source listed below to finance your osteopathic medical education through graduation from osteopathic college. Exclude loans for your undergraduate or previous postgraduate education (**see Item A1**) and non-educational debt (**see Item A6**). Please answer **TOTAL (A2k)** even if you don't know the breakout of individual loans.

a. Unsubsidized Stafford or unsubsidized Federal Family Education Loan Program (FFELP). **If none Enter zero**.

$ _ _ _ , _ _ _

b. Subsidized Stafford Loan Program or FFELP. **If none, enter zero**

$ _ _ _ , _ _ _

c. Graduate PLUS Loan Program **If none, enter zero.**

$ _ _ _ , _ _ _

d. Perkins loan. **If none, enter zero.**

$ _ _ _ , _ _ _

e. Loans for Disadvantage Students (LDS). **If none, enter zero.**

$ _ _ _ , _ _ _

f. Primary Care Loan (PCL). **If none, enter zero.**

$ _ _ _ , _ _ _

A2g. Other loans insured by a state government. **If none, enter zero.**

$ _ _ _ , _ _ _

h. Osteopathic association loans (AOA, state or local osteopathic society). **If none, enter zero.**

$ _ _ _ , _ _ _

i. Alternative loan (Robert Wood Johnson Foundation, student loan program, PEP, StillLoan, Medfunds, CitiAssist, MedEXCEL, Med-Cap, Med-Achiever, Signature Health). **If none, enter zero.**

$ _ _ _ , _ _ _

j. Other personal loans in your name. **If none, enter zero.**

$ _ _ _ , _ _ _

k. TOTAL. If none, enter zero.

$ _ _ _ , _ _ _

A3. Family Loans (omit any scholarships and loans in your name (see Item A2j): If your parents or other family members will borrow to help finance your osteopathic education, please indicate the total amount of their loan(s).

a. Total loans taken out by family members. **If none, enter zero.**

$ _ _ _ , _ _ _

b. Amount of family loans in A3a to be repaid by you. **If none, enter zero.**

$ _ _ _ , _ _ _

A4. Scholarships and grants for Medical Education: Indicate the total amount you expect to receive as scholarship/grant, fellowship funds from the sources listed below to finance your osteopathic medical education. **Exclude any scholarships or grants received to finance your undergraduate or previous postgraduate education.** Please answer **TOTAL (A4h)** even if you don't know the breakout of individual scholarships/grants, and/or fellowships.

a. National Health Service Corps Scholarship. **If none, enter zero.**

$ _ _ _ , _ _ _

b. Armed Forces Health Professions Scholarship. **If none, enter zero.**

$ _ _ _ , _ _ _

c. State government Scholarship/-grant. **If none, enter zero.**

$ _ _ _ , _ _ _

A4d. Scholarship/grant/fellowship from osteopathic school or its parent university (*e.g.*, EFN, FADHPS, SDS). **If none, enter zero.**

$ _ _ _ , _ _ _

e. Tuition waiver. **If none, enter zero.**

$ _ _ _ , _ _ _

f. Osteopathic association scholarships (AOA, state or local osteopathic society). **If none, enter zero.**

$ _ _ _ , _ _ _

g. Other sources (*e.g.*, IHS). **If none, enter zero.**

$ _ _ _ , _ _ _

h. TOTAL. If none, enter zero.

$ _ _ _ , _ _ _

A5. Estimate the percentage of total cost of your medical education that will be paid by each of the following sources. Please be sure the sum of A5a through A5g equals 100%.

a. Loans (from **Items A2 & A3b**)

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

d. Scholarships or grants (from **Item A4**)

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

e. Your savings

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

f. Earnings (including spouse's)

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

e. Parents

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

f. Other relatives

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

g. Other, specify

_____

_ _ _ %

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

A6. Non-educational Debts You Will Incur While in Medical School: Show the total amount of non-educational school debt (such as car loans, credit cards, medical expenses, and living expenses) that you will incur during medical school. Do not include your home mortgage in this figure. **If none, enter zero.**

$ _ _ _ , _ _ _

0 0 0 0 0 0
1 1 1 1 1 1
2 2 2 2 2 2
3 3 3 3 3 3
4 4 4 4 4 4
5 5 5 5 5 5
6 6 6 6 6 6
7 7 7 7 7 7
8 8 8 8 8 8
9 9 9 9 9 9

A7a. How many years do you expect to take to repay the indebtedness for your osteopathic education? (Max Yrs. 30)

_ _

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

b. Do you anticipate participating in a student loan consolidation program for repayment?

O Yes
O No
O Undecided

Part III: DEMOGRAPHIC DATA

This information is for classification purposes only and is considered confidential. *Information will only be used by AACOM and affiliated organizations in totals or averages.*

D1. Date of Birth __ __ / __ __ / __ __

D2. Sex: Male O Female O

D3. Marital Status: Married/cohabiting O Single/other O

D4. SSN __ __ __ - __ __ - __ __ __ __

AACOM asks for your Social Security Number so that we can track data longitudinally—a similar survey is administered during graduation, and this number allows us to analyze changes in responses. AACOM provides reports to the COMs only in aggregate and does not include any individual identifiers.

D5. Dependents: Including yourself, how many dependents do you support financially?

1	2	3	4	5 or more
O	O	O	O	O

D6. Ethnic background: Indicate your ethnic identification from the categories below. Please mark all that apply.

a. Black/African American O
b. American Indian/Alaskan Native O
c. White O
d. Mexican American/Chicano O
e. Puerto Rican (Mainland) O
f. Puerto Rican (Commonwealth) O
g. Other Hispanic O
h. Chinese O
i. Filipino O
j. Hawaiian O
k. Korean O
l. Vietnamese O
m. Japanese O
n. Indian/Pakistani O
o. Other Pacific Islander O
p. Southeast Asian (non-Vietnamese) O
q. Other Asian O
r. Other, specify O

_____

D7. Citizenship Status:

U.S.	O
Permanent Resident	O
Other	O Please specify _____

D8. State of Legal Residence: Use 2 letter postal abbreviation. __ __

D9. Population of city/town/area of legal residence:

a. Major metropolitan area (1,000,001 or more)	O	e. City or town (10,001 – 50,000)	O
b. Metropolitan area (500,001 – 1,000,000)	O	f. City or town (2,501 – 10,000)	O
c. City (100,001 – 500,000)	O	g. Town under 2,500	O
d. City (50,001 – 100,000)	O	h. Other	O

Please specify _____

D10. a. Father's Education: Select the **highest** level of education your father attained. Complete this item even if he is deceased.

1. Professional Degree (DO/MD, JD, DDS, etc.) **(See Item D10b below)**	O	4. Bachelor's	O
		5. Associate Degree/Technical Certificate	O
2. Doctorate (Ph.D., Ed.D., etc.)	O	6. High School Graduate	O
3. Master's	O	7. Less than High School	O

b. If your father's **professional** degree is in the Health Professions field, please select one of the following:

DO/MD O Other O

D11. a. Mother's Education: Select the **highest** level of education your mother attained. Complete this item even if she is deceased.

1. Professional Degree (DO/MD, JD, DDS, etc.) **(See Item D11b below)**	O	4. Bachelor's	O
		5. Associate Degree/Technical Certificate	O
2. Doctorate (Ph.D., Ed.D., etc.)	O	6. High School Graduate	O
3. Master's	O	7. Less than High School	O

b. If your mother's **professional** degree is in the Health Professions field, please select one of the following:

DO/MD O Other O

D12. Parents' Income: Give your best estimate of your parents' combined income before taxes for the prior year.

a. Less than $20,000	O	d. $50,000 - $74,999	O	g. $200,000 or more	O
b. $20,000 - $34,999	O	e. $75,000 - $99,999	O	h. Deceased/Unknown	O
c. $35,000 - $49,999	O	f. $100,000 - $199,999	O		

D13. Financial Independence: Do you consider yourself financially independent from your parents? Yes O No O

Thank you very much for your cooperation!

NEW YORK COLLEGE OF OSTEOPATHIC MEDICINE
INTERVIEW EVALUATION FORM – ÉMIGRE PHYSICIANS PROGRAM

Applicant:_____ **Date**:_____

State:_____

CATEGORY	CRITERIA TO BE ADDRESSED	*VALUE*	RATING
1. Oral Comprehension	Ability to understand questions, content	30	
2. Personal Presentation	Appropriate response, ability to relate to interviewers	30	
3. Verbal Expression	Clarity, articulation, use of grammar	30	
4. Overall Impression	Unique experiences, employment , research	10	
OVERALL RATING		100	

INTERVIEWER RECOMMENDATION:
Accept_____

Reject_____

COMMENTS:_____

_____

_____

_____

NAME:_____

SIGNED:_____

2. Academic (pre-clinical) course-work

Data captured during NYCOM's pre-clinical 4-year pre-doctoral program and 5-year Academic Medicine Scholars program which includes the following:

Curricular Tracks: Lecture Based-Discussion / Doctor Patient Continuum

- ✓ Pre-clinical course pass/failure rate as determined by class year (year 1 and year 2) and overall at end of year 2 (tracking each class and in aggregate for two years);
- ✓ Failure rates of (components) Nervous System course or Behavior course;
- ✓ Course grades (H/P/F);
- ✓ Exam scores;
- ✓ Scores (pass/fail rate) on Core Clinical Competency OSCE exams;
- ✓ Professionalism Assessment Rating Scale (PARS)
- ✓ Students determined as pre-clinical course dismissals (and remediated);
- ✓ Students determined double course failure (and remediated);
- ✓ Failure rates due to cognitive and/or OMM lab portions of course
- ✓ Repeat students (aligned with Learning Specialist intervention)
- ✓ Changes in academic status (attrition-as identified above);
- ✓ End-of-year class rankings.

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- Introduction to Osteopathic Medicine / Lecture-Based Discussion
- Doctor-Patient Continuum (DPC) – Biopsychosocial Sciences I Grading and Evaluation Policy
- DPC – Clinical Sciences II – Grading Policy
- Assessing the AOA Core Competencies at NYCOM
- Institute for Clinical Competence (ICC) Professionalism Assessment Rating Scale (PARS)
- SimCom-T(eam) Holistic Scoring Guide
- Case A – Dizziness, Acute (scoring guides)

Samples of the forms/questionnaires follow

Introduction to Osteopathic Medicine / Lecture-Based Discussion

Grading and Evaluation

1. At the conclusion of this course, students will receive a final cognitive score and a final OMM laboratory score.
2. Both a student's final cognitive score and a student's final OMM laboratory score must be at a passing level in order to pass this course.
3. Cognitive Score
    a. A student's cognitive score is comprised of the following two components:
        i. Written Examinations and Quizzes pertaining to course lectures and corresponding required readings, cases, course notes, and PowerPoint presentations
        ii. Anatomy Laboratory Examinations and Quizzes
    b. The weighting of the two components of the final cognitive score is as follows:

Summary of Cognitive Score Breakdown

Cognitive Score Component	% of Final Cognitive Score
Written Examinations and Quizzes	75%
Anatomy Laboratory Examinations and Quizzes	25%
Total Cognitive Score	100%

    c. Written Examinations and Quizzes
        i. There will be three written examinations and four written quizzes in this course.
        ii. The written examinations and quizzes will consist of material from all three threads (Cellular and Molecular Basis of Medicine, Structural and Functional Basis of Medicine, Practice of Medicine).
        iii. Up to 25% of the written exam and quiz material will come from directed readings.
        iv. For the purpose of determining passing for this course, the written examinations will be worth 90% of the final written score and the quizzes will be worth 10% (2.5% each) of the final written score. This weighting is illustrated in the following table:

Summary of Written Exam/Quiz Score Breakdown

Written Exam/Quiz #	% of Final Written Score
Written Exam #1	25%
Written Exam #2	30%
Written Exam #3	35%
Total Written Exam Score	90%
Written Quiz #1	2.5%
Written Quiz #2	2.5%
Written Quiz #3	2.5%
Written Quiz #4	2.5%
Total Written Quiz Score	10%
Total Written Score	100%

    d. Anatomy Laboratory Examinations and Quizzes
        i. There will be two Anatomy laboratory examinations in this course
        ii. There will be Anatomy laboratory quizzes in this course, conducted during Anatomy laboratory sessions.
        iii. For the purpose of determining passing for this course, each Anatomy lab examination

will be worth 45% of students' final Anatomy lab score and all Anatomy lab quizzes combined will be worth 10% of students' final Anatomy lab score. This weighting is illustrated in the following table:

Summary of Anatomy Lab Exam/Quiz Score Breakdown

Anatomy Lab Exam/Quiz #	% of Final Anatomy Score
Anatomy Lab Exam #1	45%
Anatomy Lab Exam #2	45%
Anatomy Lab Quizzes	10%
Total Anatomy Lab Exam/Quiz Score	100%

4. OMM Laboratory Score
    a. A student's OMM laboratory score in this course is comprised of an OMM laboratory examination and laboratory quizzes, as follows:
        i. There will be one OMM laboratory practical examination in this course
        ii. There will be two OMM laboratory practical quizzes in this course conducted during OMM laboratory sessions
        iii. There will be a series of OMM laboratory written quizzes in this course conducted during OMM laboratory sessions.
    b. The weighting of the components of the OMM laboratory final score is as follows: For the purpose of determining passing for this course, the OMM laboratory practical examination will be worth 70% of the final OMM laboratory score, the OMM laboratory practical quizzes will be worth 20% (10% each) of the final OMM laboratory score, and the OMM laboratory written quizzes will be worth 10% (all OMM lab written quizzes combined) of the OMM laboratory score. This weighting is illustrated in the following table:

Summary of OMM Laboratory Exam/Quiz Score Breakdown

OMM Laboratory Exam/Quiz	% of Final OMM Laboratory Score
OMM Laboratory Practical Exam	70%
OMM Laboratory Practical Quiz #1	10%
OMM Laboratory Practical Quiz #2	10%
OMM Laboratory Written Quizzes (all quizzes combined)	10%
Total OMM Laboratory Score	100%

5. Examinations and quizzes may be cumulative.
6. Honors Determination
    a. For the purpose of determining who will be eligible to receive a course grade of Honors ("H"), the final cognitive score and final OMM laboratory score will be combined in a 75%/25% ratio, respectively.
    b. Using the formula noted above, students scoring in the top 10% (and who have not taken a make-up exam within the course or remediated the course) will receive a course grade of Honors.

DOCTOR PATIENT CONTINUUM(DPC) - BIOPSYCHOSOCIAL SCIENCES I

Grading and Evaluation Policy:

The examinations and evaluations are weighed as follows:

Evaluation Criteria:	Percent of Grade
Content Examination	55%
Component Examinations	25%
Facilitator Assessment	20%

Content Examination: There will a mid-term exam and an end of the term exam, each weighted equally. The examinations will cover the learning issues submitted by the case-study groups. Questions will be based on the common learning issues (covered by all groups) and learning issues specific to individual groups (unique issues).

Component Exams: Distribution of the component exams will be as follows:

- Exams based on Anatomy lectures and labs = 20%
- Graded assignments offered by problem set instructors, which might include quizzes, position papers, and/or other exercises = 5%

Facilitator Assessment: Facilitators will meet individually with students twice during the term to evaluate their performance. The first evaluation will be 'formative' only, i.e., to advise students of their progress and will not be recorded for grade. The end of the term evaluation will be used to assess the student's progress/participation in the group and other class related activities. Students will also complete Self-Assessment Forms to supplement the evaluation process.

The grading of this course is on a "PASS/FAIL/HONORS" basis.

1) Students will be evaluated each Term using the multiple components as described above.
2) Each year at the end of the 1st Term:
   a) All students will be assigned an interim grade of I (Incomplete);
   b) Each student will be informed of his/her final average, a record of which will be maintained in the office of the DPC Academic Coordinator and the Director of the DPC program.
3) Students who earn less than a 1st-Term average of 70%, or a content exam score of <65%, will be officially informed that their performance was deficient for the 1st Term. The student, in consultation with the Course Coordinator, will present a plan designed to resolve the deficiency. This information will also be forwarded to the Associate Dean of Academic Affairs for tracking purposes.
4) Students with a 1st-Term average <70%, or a content exam score of <65%, will be allowed to continue with the class. However, in order to pass the year the student must achieve a final yearly average (1st- and 2nd-term) of 70% or greater with a content exam average (for the two Terms) of 65% or greater.
5) All students who meet the requirements for passing the year (see 4) will then be awarded the grade of P (Pass) or H (Honors) for each of the two Terms.

6) Students who fail the year (see 4) will be awarded a grade of I (Incomplete) and will be permitted (with approval of the Associate Dean for Academic Affairs) to sit for a comprehensive reassessment-examination. The reassessment exam will be constructed by the course faculty and administered by the Course Coordinator. The exam may include both written and oral components. Successful completion of the reassessment examination will result in the awarding of a grade of P for the two Terms. Failure of the comprehensive reassessment exam will result in the awarding of a grade of F (Fail) for the two terms, and a recommendation to the Associate Dean of Academic Affairs that the student be dismissed from the College.

7) Students whose failure of the year (i.e. overall yearly average <70%) can be attributed to low facilitator assessment scores present a special concern. The student has been determined, by his/her facilitators, to be deficient in the skills necessary to effectively interact with patients and colleagues. This deficiency may not be resolvable by examination. Such failures will be evaluated by the Director of the DPC program, the Associate Dean of Academic Affairs and/or the Committee on Student Progress (CSP) to determine possible remediation programs or to consider other options including dismissal.

DOCTOR PATIENT CONTINUUM(DPC) – CLINICAL SCIENCES II

Grading Policy:

1. The grading of this course is on a "PASS/FAIL/HONORS" basis. Grades will be determined by performance in the three components of the course, OMM, Clinical Skills, and Clinical Practicum, as follows:

Evaluation Criteria:	Percent of Grade
OMM	40%
Clinical Skills	40%
Clinical Practicum	20%

In both the OMM and Clinical Skills components of the course, student evaluations will encompass written and practical examinations. In order to pass the course, both the written and practical examinations in OMM AND Clinical Skills must be passed. Students who fail to achieve a passing score in either Clinical Skills or OMM will be issued a grade of "I" (Incomplete). Such students will be offered the opportunity to remediate the appropriate portion of the course. Re-evaluation will be conducted under the supervision of the DPC faculty. Successful completion of the re-evaluation examination, both written and practical, will result in the awarding of a grade of P (Pass). Failure of the comprehensive reassessment exam will result in the awarding of a grade of U (Unsatisfactory) for this course.

2. Grading of the OMM component will be evaluated according to the following criteria:

Evaluation Criteria:	Percent of Grade
OMM written (weighted)	50%
OMM practical (average)	50%

3. Grading of the Clinical Practicum component will be evaluated according to the following criteria:

Evaluation Criteria:	Percent of Grade
Attendance and Participation	15%
Case Presentation	35%
Clinical Mentor Evaluation	50%

4. Grading of the Clinical Skills component will be evaluated according to the following criteria:

Evaluation Criteria:	Percent of Grade
Class participation/assignments	5%
ICC participation/assignments	10%
Timed examination #1	
– Practical portion	20%
– Written portion	5%
Timed examination #2	
– Practical portion	20%
– Written portion	5%
Timed Comprehensive examination	
– Practical portion	25%
– Written portion	10%

Assessing the American Osteopathic Association (AOA) Core Competencies at New York College of Osteopathic Medicine (NYCOM)

A. Background

In recent years, there has been a trend toward defining, teaching and assessing a number of *core competencies* physicians must demonstrate. The Federation of State medical Boards sponsored two Competency-Accountability Summits in which a "theoretical textbook" on good medical practice was drafted to guide the development of a competency-based curriculum. The competencies include: medical knowledge, patient care, professionalism, interpersonal communication, practice-based learning, and system-based practice. The AOA supports the concepts of core competency assessment and added an additional competency: osteopathic philosophy and osteopathic clinical medicine.

Arguably it is desirable to begin the process of core competency training and assessment during the pre-clinical year. Patient simulations, i.e. using standardized patients and robotic simulator, allow for such training and assessment under controlled conditions. Such a pre-clinical program provides basic clinical skills acquisition in a patient-safe environment. NYCOM has responded to this challenge by creating a two-year "Core Clinical Competencies" seminar that requires students to learn and practice skills through various patient simulations in the Institute For Clinical Competence (ICC). In this seminar the ICC assesses a sub-set of the above competencies taught in the lecture-based and discussion-based clinical education tracks.

The following is a list of the competencies assessed during the pre-clinical years at NYCOM, and reassessed during the third year (osteopathic medicine *objective structured clinical examination*) and fourth year (voluntary *Clinical Skills Capstone Program*). It should be noted that there is a fair amount of skills overlap between the competencies, for example, the issue of proper communication can be manifested in a number of competencies.

B. Core Clinical Competencies

1. *Patient Care:* Provide compassionate, appropriate effective treatment, health promotion

Skills:
- Data-gathering: history-taking, physical examination (assessed with clinical skills checklists)
- Develop differential diagnosis
- Interpret lab results, studies
- Procedural skills, e.g. intubation, central line placement, suturing, catheterization
- Provide therapy

2. *Interpersonal and communication skills:* Effective exchange of information and collaboration with patients, their families, and health professionals.

Skills:
- Communication with patients and their families across a spectrum of multicultural backgrounds (assessed with the Professionalism Assessment Rating Scale)

- Health team communication
- Written communication (SOAP note, progress note)

3. *Professionalism:* Commitment to carrying out professional responsibilities and ethical committments

Skills:
- Compassion, respect, integrity for others
- Responsiveness to patient needs
- Respect for privacy, autonomy
- Communication and collaboration with other professionals
- Demonstrating appropriate ethical consideration
- Sensitivity and responsiveness to a diverse patient population including e.g. gender, age, religion, culture, disabilities, sexual orientation.

4. *Osteopathic Philosophy and Osteopathic Clinical Medicine:* Demonstrate, apply knowledge of osteopathic manipulative treatment (OMT); integrate osteopathic concepts and OMT into medical care; treating the person, and not just the symptoms

Skills:
- Utilize caring, compassionate behavior with patients
- Demonstrate the treatment of people rather than the symptoms
- Demonstrate understanding of somato-visceral relationships and the role of the musculoskeletal disease
- Demonstrate listening skills in interaction with patients
- Assessing disease (pathology) and illness (patient's response to disease)
- Eliciting psychosocial information

C. Assessment of Core Competencies

The ICC utilizes *formative assessment* to evaluate learner skills and the effectiveness of NYCOM's clinical training programs. Data on student performance in the ICC is tracked from the first through the fourth year. The ICC satellite at St. Barnabas assesses students during their clerkship years as well as interns and residents in a number of clinical services. It uses a variety of methods to assess competencies:

1. Written evaluations
- Analytic assessment – skills checklists that document data-gathering ability
- Global-holistic rating scales to assess doctor-patient communication (Professionalism Assessment Rating Scale) and health team communication (SimCom-T)
- SOAP note and progress note assessment

2. Debriefing / feedback – a verbal review of learner actions following a patient simulation program provided by standardized patients and instructors as appropriate.

Core Clinical Competencies 590 (MS 1)
Core Clinical Competencies 690 (MS 2)

The courses provide a horizontal integration between clinical courses provided by the LDB and DPC programs (small group discussion and demonstration) and the OMM department. It provides practice with simulated patients (some variation in this aspect as noted below), formative assessment, end-of-year summative assessment and remediation.

1. SP PROGRAM, METRICS AND HOURS

MS 1 Program – SP Different program, same standardized examination

LDB
- SP program: training with formative assessment (see next bullet for formative assessment metrics)
- End of year OSCE assessing history-taking (checklists designed for each SP case), PE (see attached physical examination criteria) and interpersonal communication (see attached program in doctor-patient communication "Professionalism Assessment Rating Scale)
- Hours: 13.5 / year (including OSCE)

DPC
- Clinic visits to substitute for SP encounters
- End of year OSCE (same as LDB)
- Hours: Should be equivalent to the number of SP hours in the LDB program

NOTE: The purpose of the OSCE is to assess the clinical training of both the LDB and DPC programs. It is assumed the LDB and DPC faculty will work on this OSCE together with the OMM department.

MS 1 Program – Patient Simulation Program

LDB and DPC

- Same program in basic procedures for both LDB and DPC students as outlined in the syllabus distributed during the curriculum committee
- Hours: 5 hours / year

MS 2 Program – SP

LDB and DPC – same program, different approaches, same standardized exam

- SP program: training with formative assessment (see next bullet for formative assessment metrics)
- End of year OSCE assessing history-taking (checklists designed for each SP case), PE (see attached physical examination criteria) and interpersonal communication (see attached program in doctor-patient communication "Professionalism Assessment Rating Scale)
- Hours: 13.5 hours / year (including OSCE)
- NOTE: It is assumed that the LDB and DPC program schedules will vary but that the content will be equivalent

MS 2 Program – Patient Simulation Program

LDB and DPC – same program, same standardized exam

- Students work in the same group throughout the year

End of year OSCE assessing medical team communication using the SimCom-T rating scale (attached)

- Group grade assigned for the OSCE (reflecting the spirit of the SimCom-T rating scale)
- Hours: 11 / year (including OSCE)

2. Attendance

- All activities and exams are mandatory.
- Make ups are done at the discretion of the ICC

NOTE: Make ups will be done as close to an activity as possible because delaying them, e.g. to the end of the year, will incur additional training expenses (e.g. re-training a SP for a case played months earlier) for the ICC.

3. Grading and remediation

- Pass / fail
- Grading is based upon:
    - Attendance
    - Participation
    - End-of-year OSCE (standards to be set)

ICC Hours

MS1	Clinical Practice	OSCE	Total Hours
LDB	8 SP exercises @1.5 hours each 12 hours per student 5 patient simulation program exercises @ 1 hours each 5 hours per student	End-of-year SP OSCE 1.5 hours per student (approximately 6.25 days)	13.5 hours (SP) 5 hours (Pat Sim) Total = 18.5
DPC	Clinic experience to substitute for SP exercises ▪ Students will receive information re: communication and PE competencies 5 patient simulation program exercises @ 1 hours each 5 hours per student		0 hours (SP) 5 hours Pat Sim Total = 5

MS2	Clinical Practice	OSCE	Total Hours
LDB DPC	8 SP exercises @1.5 hours each 12 hours per student 6 patient simulation program exercises, plus ACLS 10 hours per student	End-of-year SP OSCE 1.5 hours per student (approximately 6.25 days) End-of-year Pat Sim OSCE 1 hour per student (approximately 5 days)	13.5 hours (SP) 11 hours (Pat Sim) Total = 24.5

Institute For Clinical Competence (ICC)
Professionalism Assessment Rating Scale (PARS)

Dear Students:

As part of your professional development, standardized patients (SPs) in the ICC will be evaluating your *interpersonal communication* with them using the *Professionalism Assessment Rating Scale (PARS)*.

This scale evaluates two types of interpersonal communication, both important to quality health care:

- *Patient Relationship Quality* – Rapport, empathy, confidence and body language.
- *Patient Examination Quality* – Questioning, listening, information exchanging and careful and thorough physical examination.

Arguably patients (real or simulated) are in the best position to assess your interpersonal communication with them because *you* are directly relating to *them* during an intimate, face-to-face, hands-on encounter. They are in the best position, literally, to observe your eye contact, demeanor and body language because they are in the room with you. We would recommend you take their feedback seriously, but perhaps "with a grain of salt."

The term *standardized patient* is to some degree a misnomer – SPs can be standardized to present the same challenge and the same medical symptoms to each student, *but they cannot be standardized to feel the same way about you and your work with them compared to other students.* This is true in life as well as clinical work – some people will like you better than others, and patients are people! You may communicate with one patient the way you do with the next, but receive slightly different ratings. This is to be expected. Unlike the analytic checklists we use to document if you asked particular questions or performed certain exams correctly, *there are no dichotomous / "right or wrong" communication ratings.* Patients are people who may tune into different things during an encounter. We think this slight variation in observation is an asset that will help you understand that patients are individuals who must be approached as individuals.

Another word about the ratings you will receive – the ratings are not absolute numbers that constitute an unconditional assessment of your communication skills. Some days you may be better than other days. We use the ratings numbers (1-8 holistic scale) to chart progress over time. We do see improvements during the first two years of the typical student's training but the ratings are used to track your progress as much as to structure a conversation with the SP, or faculty member, during debriefing. We would recommend you take responsibility during SP debriefing and ask them questions about the work you just did.

The holistic 1 - 8 scale is broken down into two parts: Ratings of 1 - 4 are considered "lower quality" communication, i.e. what might be considered acceptable at a novice or trainee level, but less acceptable for an experienced professional. Ratings of 5 – 8 are considered "higher quality" communication, i.e. more professional-quality communication regardless of the training or experience level.

Professionalism Assessment Rating Scale (PARS)

Standardized patients will rate "to what degree" you demonstrated *relationship quality* and *examination quality* on the following nine factors:

	RELATIONSHIP QUALITY To what degree did the student …	**Lower Quality**							**Higher Quality**
1	Establish and maintain rapport	1	2	3	4	5	6	7	8
2	Demonstrate empathy	1	2	3	4	5	6	7	8
3	Instill confidence	1	2	3	4	5	6	7	8
4	Use appropriate body language	1	2	3	4	5	6	7	8
	EXAMINATION QUALITY To what degree did the student …	**Lower Quality**							**Higher Quality**
5	Elicit information clearly, effectively	1	2	3	4	5	6	7	8
6	Actively listen	1	2	3	4	5	6	7	8
7	Provide timely feedback / information / counseling	1	2	3	4	5	6	7	8
8	Perform a thorough, careful physical exam or treatment	1	2	3	4	5	6	7	8

Less experienced, or unprofessional **More professional**

The following pages are a guide to the PARS, giving examples of "lower quality" and "higher quality" communication.

1 Establish and maintain rapport

Establish and maintain a positive, respectful collaborative working relationship with the patient.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Overly familiar. ▪ *"Hi Bill, I'm John. How are you doing today."*	Appropriate address, e.g. ▪ *"Hi Mr. Jones, I'm Student-doctor Smith. Is it OK if I call you Bill?"*
No agenda set. No collaboration with the patient, i.e. carries out the exam without patient consent or agreement.	Set agenda, e.g. ▪ *"We have ___ minutes for this exam. I'll take a history, examine you…..etc."* Collaborative mindset ▪ *"Let's figure out what's going on."* ▪ *"We're going to work out this problem together."*
Took notes excessively, i.e. spent more time taking notes than interacting.	Spent more time interacting with the patient than taking notes.
Began physically examining patient without "warming" patient up, asking consent, etc.	Asked consent for obtaining a physical examination, e.g. ▪ *"Is it OK for me to do a physical exam?"*
Did not protect patient's modesty, e.g. ▪ Did not use a drape sheet ▪ Did not direct patient to get dressed after exam ▪ Left door open when examining patient.	Respected patient's modesty at all times e.g. ▪ Used a drape sheet when appropriate ▪ Letting patient cover up follow an examination.
Talked "down" to patient, did not seem to respect patient's intelligence.	Seemed to assume patient is intelligent.
Rude, crabby or overtly disrespectful.	Never rude, crabby; always respectful.
Dress, hygiene problems: ▪ Wore distracting perfume/cologne. ▪ Poor hygiene, e.g. uncleanly, dirty nails, body odor, did not wash hands, etc. ▪ Touched hair continually ▪ Unprofessional dress, e.g. wore jeans, facial jewelry (e.g. tongue or nose studs), overly suggestive or revealing garments	Dressed professionally, i.e. in a clean white coat, clean clothes, etc.
Seemed angry with the patient.	Seemed to like the patient.

2 Demonstrate empathy

Demonstrate both empathy (compassion, understanding, concern, support) and inquisitiveness (curiosity, interest) in the patient's medical problem and life situation.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
EMPATHY	
No expressions of concern about patient's condition or situation.	Expressed concern about patient's condition or situation, e.g. ▪ *"That must be painful."* ▪ *"I'm here to try to help you."*
Failed to acknowledge positive behavior / lifestyle changes the patient has made.	Reinforced behavior/lifestyle changes the patient has made, e.g. "That's great you quit smoking."
Failed to acknowledge suggested behavior / lifestyle changes might be difficult.	Acknowledged that suggested behavior/lifestyle changes might be difficult.
Empathic expression seemed insincere, superficial.	Empathic expressions seemed genuine.
Detached, aloof, overly "business-like," robotic in demeanor. Seeming lack of compassion, caring.	Compassionate and caring, "warm."
Accused patient of being a non-compliant, e.g. ▪ *"Why don't you take better care of yourself?"* ▪ *"You should have come in sooner."*	Positive reinforcement of things patient is doing well, e.g. ▪ *"That's great that you stopped smoking."* ▪ *"I'm glad you are taking your medication on a regular basis.*
INQUISITIVENESS – An aspect of empathy is *inquisitiveness,* the ability to attempt to understand the patient, both medically and personally.	
Focused on symptoms, but not the patient, i.e. did not explore how the medical problem / symptoms affect the patient's life. Failed to explore *activities of daily living.*	Tried to understand how the medical problem / symptoms affect the patient's life, or vice versa. ▪ *"How is this affecting your life?"* ▪ *"Tell me about yourself."* ▪ *"Describe a typical day in your life."* ▪ *"Tell me about your stress."*
Failed to explore patient's response to diagnosis and / or treatment.	Inquires as to patient's response to diagnosis and / or treatment
Failed to explore barriers to behavior / lifestyle change.	Explored barriers to behavior / lifestyle change.

3 Instill confidence

Instilling confidence that the medical student or doctor is able to help and treat the patient.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Conveyed his / her anxiety, e.g. ▪ By avoiding eye contact ▪ Laughing or smiling nervously ▪ Sweaty hand shake Made statement such as: ▪ *"This is making me nervous."* ▪ *"This is the first time I've ever done this."* ▪ *"I don't know what I'm doing."* Apologized inappropriately to the patient. E.g. ▪ *"I'm sorry, but I have to examine you."*	Conveyed an appropriately confident demeanor, e.g. ▪ Made eye contact ▪ Shook hands firmly, etc.
Overly confident, cocky.	Never cocky, appropriately humble without undermining the patient's confidence.
When making suggestions, used tentative language, e.g. ▪ *"Maybe you should try…"* ▪ *"I'm not sure but …"*	When making suggestions, used authoritative language, e.g. ▪ *"What I suggest you do is…"*
Made excuses for his/her lack of skill or preparation by making statements such as: ▪ *"I'm just a medical student."* ▪ *"They didn't explain this to me."* ▪ *"Do you know what I'm supposed to do next?"*	Offered to help the patient or get information if he / she could not provide it by saying, e.g. ▪ *"Let me ask the attending physician"* ▪ *"I don't know but let me find out for you."*

4 Use appropriate body language The ability to use appropriate gestures, signs and body cues.	
Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Overly casual posture, e.g. leaning against the wall or putting feet up on a stool when interviewing the patient.	Professional posture, i.e. carried himself / herself like an experienced, competent physician.
Awkward posture, e.g. • Stood stiffly when taking a history • Stood as if he / she was unsure what to do with his / her body.	Natural, poised posture.
Uncomfortable or inappropriate eye contact e.g. stared at the patient too long and / or never looked at the patient.	Used appropriate eye contact.
Avoided eye contact when listening.	Made eye contact when listening, whether eye level of not.
Stood or sat too close or too distant from the patient.	Maintained an appropriate “personal closeness” and “personal distance.”
Turned away from the patient when listening.	Maintained appropriate body language when listening to the patient.

5 Elicit information clearly, effectively

Effectively ask questions in an articulate, understandable, straightforward manner.

Lower Quality 1 2 3 4	Higher Quality 5 6 7 8
Used closed-ended, yes / no questions exclusively, e.g. ▪ *"How many days have you been sick?"* ▪ *"Ever had surgery?"* ▪ *"Any cancer in your family?"*	Used open-ended questions to begin an inquiry, and closed-ended questions to clarify, e.g. ▪ *"Tell me about the problem."* ▪ *"What do you do in a typical day?"* ▪ *"How is your health in general?"*
Used open-ended questions / non-clarifying questions exclusively.	Used open-ended questions to begin an inquiry, and closed-ended questions to clarify.
Student's questions were inarticulate, e.g. mumbled, spoke too fast, foreign accent problems, stuttered*, etc. * NOTE: Consider stuttering a form of inarticulation for rating purposes, i.e. do not make allowances for stuttering	Student was articulate, asked questions in an intelligible manner.
Asked confusing, multi-part or overly complex questions, e.g. ▪ *"Tell me about your past medical conditions, surgeries and allergies."*	Asked one question at a time, in a straight-forward manner. ▪ *"Tell me about your allergies."*
Asked leading questions, e.g. ▪ *"No cancer in your family, right?"* ▪ *"No surgeries?"* ▪ *"You only have sex with your wife, right?"*	Asked direct questions, e.g. ▪ *"Do you have any cancer in your family?* ▪ *"Any surgeries?"* ▪ *"Are you monogamous?"*
Jumped from topic to topic in a "manic," disjointed or disorganized way.	Organized interview. Stayed focused, asked follow up questions before moving to another topic.
Asked questions in a robotic way, i.e. as if reading from a prepared checklist.	Asked questions in a conversational way, i.e. listened to the response, and then asked another question.
Constantly cut off patient, i.e. did not let patient finish sentences.	Allowed patient to finish sentences and thoughts before asking the next question.

6 Actively listen Both listen and respond appropriately to the patients' statements and questions.	
Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Asked questions without listening to the patient's response.	Asked questions and listened to patient's response.
No overt statements made indicating he / she was listening.	Said, e.g. "I'm listening."
Turned away from the patient when listening.	Maintained appropriate body language when listening to the patient.
Kept asking the same question(s) because the physician didn't seem to remember what he / she asks.	If necessary, asked the same questions to obtain clarification, e.g. ▪ *"Can you tell me again how much you smoke?"* ▪ *"I know you told me this, but when was the last time you saw your doctor?"*
Wrote notes without indicating he / she was listening.	When writing indicated he / she is listening, e.g. ▪ *"I have to write down a few things down when we talk, OK?"*
Did not seem to be listening, seemed distracted.	Attentive to the patient.
Kept talking, asking questions, etc. if the patient was discussing a personal issue, a health concern, fear, etc.	Was silent when necessary, e.g. if the patient was discussing a personal issue, a health concern, fear, etc.

7 Provide timely feedback / information / counseling

Explain, summarize information (e.g. results of physical exams, provides patient education activities, etc.), or provide counseling in a clear and timely manner.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Did not explain examination procedures, e.g. just started examining the patient without explaining what he / she was doing.	Explained procedures, e.g. ▪ *"I'm going to check your legs for edema."* ▪ *"I'm going to listen to your heart."*
Did not provide feedback at all, or provided minimal feedback	Periodically provided feedback regarding what he / she heard the patient saying. ▪ *"It sounds like your work schedule makes it difficult for you to exercise."* ▪ *"I hear in your voice that your family situation is causing you a lot of stress."*
Did not summarize information at all.	Periodically summarized information. ▪ *"You had this cough for 3 weeks, it's getting worse and now you've got a fever. No one is sick at home and you haven't been around anyone who is sick."*
Provided empty feedback or unprofessional feedback, e.g. ▪ *"OK…..OK…..OK…..OK…"* ▪ *"Gotcha..gotcha…gotcha,.."* ▪ *"Great " "Awesome" "Cool"*	Feedback was meaningful, useful and timely.
Examined the patient without providing feedback about the results of the exam.	Provided feedback about results of the physical exam. ▪ *"Your blood pressure seems fine."*
Refused to give the patient information he / she requested, e.g. "You don't need to know that." "That's not important."	Give information to the patient when requested, or offered to get it if he / she couldn't answer the patient's questions.
Used medical jargon without explanation, e.g. ▪ *"What you experienced was a myocardial infarction."*	Explained medical terms. ▪ *"What you experienced is a myocardial infarction, meaning a heart attack."*
Ended the exam abruptly. No closure, no information about the next steps	Let the patient know what the next step was, provided closure. ▪ *"Let's review the exam and your health…"*

8 Conduct a thorough, careful physical exam or treatment

Conduct physical exams and / or treatment in a thorough, careful manner vs. a tentative or superficial manner.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
Conducted a superficial examination, e.g. ▪ Avoided touching the patient ▪ Touched patient with great tentativeness	Conducted a careful examination, e.g. ▪ Examined on skin when appropriate
Hurried through the exam.	Used the full amount of time allotted to examine the patient.
Avoided inspecting (looking at) the patient's body / affected area.	Thoroughly inspected (looked at) the affected area e.g. with gown open.
Consistently palpated, auscultated and / or percussed over the exam gown.	Consistently palpated, auscultated and / or percussed on skin.
Exam not bi-lateral (when appropriate).	Bi-lateral exam (when appropriate).
Rough exam, e.g. ▪ Started, stopped, re-started the exam. ▪ Fumbled with instruments	Conducted a smooth exam from beginning to end.
Did not look to see what patient's expressions were during an examination in order to assess pain.	Looked for facial expressions to assess pain.
Did not thoroughly examine the site of the chief complaint, e.g. ▪ Did not examine heart and / or lungs if chief complaint was a breathing problem	Thoroughly examined the site of the chief complaint.

9 Conduct the examination in an organized manner

Overall conduct the exam in an organized, systematic way vs. a disorganized or unsystematic way.

Lower Quality **1 2 3 4**	**Higher Quality** **5 6 7 8**
No clear opening, e.g. ▪ Did not set an agenda ▪ Abruptly began the exam Medical interview not organized – history jumped from topic to topic No clear closure, e.g. ▪ Did not summarize information gathered during the history and physical examination ▪ Did not ask patient *"Any more questions?"* ▪ Did not clarify next steps	Clear opening, e.g. ▪ Set an agenda and followed it ▪ Began the exam after a proper introduction Organize the medical interview vs. jumping from topic to topic Clear closure, e.g. ▪ Summarized information gathered during the history and physical examination ▪ Asked patient "Any more questions?" ▪ Clarified next steps

SimCom-T(eam) Holistic Scoring Guide

The SimCom-T is a holistic health care team communication training program and rating scale. The nine-factor scale of SimCom-T rates team members' performance *as a unit,* i.e. individual team member performance should be considered a reflection upon the entire team.

Rate each factor individually.
Ratings should be *global,* i.e. reflect the most characteristic performance of the team vs. individual incidents.

	Competency	**Lower Quality**			**Higher Quality**		
1	Leadership establishment and maintenance	1	2	3	4	5	CNE
2	Global awareness	1	2	3	4	5	CNE
3	Recognition of critical events	1	2	3	4	5	CNE
4	Information exchange	1	2	3	4	5	CNE
5	Team support	1	2	3	4	5	CNE
6	External team support	1	2	3	4	5	CNE
7	Patient support	1	2	3	4	5	CNE
8	Mutual trust and respect	1	2	3	4	5	CNE
9	Flexibility	1	2	3	4	5	CNE
10	Overall Team Performance	1	2	3	4	5	CNE

The following pages are a guide to SimCom-T, providing behavioral examples representative of each score for the SimCom-T competencies.

Score	**Performance Level**	**Description – The team…**
1	*Limited*	….consistently demonstrates novice and / or dysfunctional team attributes
2	*Basic*	….inconsistently operates at a functional level
3	*Progressing*	….demonstrates basic and average attributes
4	*Proficient*	….proficient and consistent in performance
5	*Advanced*	….experienced and performing at a significant expert level
CNE	Not applicable	….A factor could not be evaluated for some reason

1. Leadership Establishment and Maintenance

Team members both establish leadership and maintain leadership throughout.

	Lower Quality				Higher Quality	
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Leader not established ▪ Roles not assigned ▪ No discussion regarding role assignment	▪ Unable to identify leader ▪ Many leaders ▪ No clear role definition	▪ Leadership not explicit throughout event ▪ Leadership not maintained throughout the event ▪ Role switching without leader involvement	▪ Leader explicitly identified ▪ Roles defined	▪ Leadership explicitly identified and maintained ▪ Roles defined and maintained ▪ Leader delegates responsibility	
Examples	▪ Team operating dysfunctionally without a leader ▪ Team members taking on similar roles and role switching consistently ▪ Team members unsure of who is responsible for different tasks	▪ Leader timid and does not take charge ▪ Team member roles unclear and/or inconsistent	▪ A team member asks, “Who is running the code?” and another says, “I am,” but does not take communicate leadership responsibilities. ▪ Team members are assigned roles but do not take on the assignment	▪ Team members select a leader ▪ A team member volunteers to handle the situation ▪ Roles clearly defined by team members and/or leader	▪ Leadership and roles are established very early in the event and is maintained throughout the event ▪ Clarity of leadership and roles is evident throughout the event and with the team members	

2. Global Awareness

Team members monitor and appropriately respond to the total situation, i.e. the work environmental and the patient's condition.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Does not monitor the environment and patient ▪ Does not respond to changes in the environment and patient	▪ Monitoring and response to changes in the environment and patient rarely occur ▪ Fixation errors	▪ Monitoring and response to the environment and patient are not evident throughout the event	▪ Monitors the environment and patient ▪ Respond to changes in the environment and patient	▪ Consistently monitors the environment and patient ▪ Consistently respond to changes in the environment and patient	
Examples	▪ There is no summary of procedures, labs ordered, or results of labs ▪ Team is task oriented and does not communicate about the event	▪ Event manager loses focus and becomes task oriented ▪ There is no clear review of the lab results and/or summary of procedures.	▪ Leader says, "Team, lets review our differential diagnosis and labs," and team does not respond to the leader. ▪ Some of the team members discuss among themselves results and possible problems.	▪ Leader says, "Team, lets review our differential diagnosis and labs," and team reviews the situation. ▪	▪ Event manager remains at the foot of the bed keeping a global assessment of the situation ▪ Leader announces plan of action for the event.	

3. Recognition of Critical Events

Team promptly notes and responds to critical changes in the patient's status and / or environment.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Does not monitor or respond to *critical* deviations from steady state ▪ Fails to recognize or acknowledge crisis ▪ "Tunnel Vision"	▪ Fixation errors are consistently apparent ▪	▪ Team reactive rather than proactive ▪ Critical deviations from steady state are not announced for other members	▪ Monitors and responds to *critical* deviations from steady state ▪ Recognizes need for action	▪ All team members consistently monitors and responds to *critical* deviations from steady state ▪ Anticipates potential problems ▪ Practices a proactive approach and attitude ▪ Recognizes need for action ▪ "Big Picture"	
Examples	▪ Patient stops breathing, and team does not recognize the situation throughout the event ▪ Patient is pulseless, and no CPR is started throughout the event	▪ Patient stops breathing, and team does not recognize this situation for a *critical time period* ▪ Patient is pulseless, and no CPR is started for a *critical time period*	▪	▪ Leader says, "Team, lets review our differential diagnosis, are there any additional tests that we should request?"	▪ "John, the sats are dropping, please be ready, we might have to intubate." ▪ "Melissa, the blood pressure is dropping. Get ready to start the 2nd IV and order a type and cross."	

4. Information Exchange

Patient and procedural information is exchanged clearly.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Communication between team members is not noticeable ▪ Requests by others are not acknowledged ▪ No feedback loop ▪ No orders given	▪ Vague communication between team members ▪ Not acknowledging requests by others ▪ Feedback loop left opened ▪ Orders not clearly given	▪ Communication between team and response to requests by others inconsistent ▪ Feedback loops open and closed ▪ Orders not directed to a specific team member	▪ Team communicates and acknowledges requests throughout the event ▪ Feedback loops closed	▪ Explicit communication consistently throughout the event ▪ Team acknowledges communication ▪ Closed loop communication throughout event	
Examples	▪ No summary of events. ▪ No additional information sought from the team members.	▪ Event manager says, "I need a defibrillator, we might have to shock this patient," and no team member acknowledges the order. The request was not given explicitly to a team member. ▪	▪ One team member says to another in a low voice, "We need to place a chest tube," but the event manager does not hear the communication. ▪ Event manager requests a defibrillator, but not explicitly to a particular team member; several team members attempt to get the defibrillator	▪ Jonathan says to event manager, "We need to place a chest tube." Event manager responds, "OK, get ready for it." ▪ Leader says, "Team, lets summarizes what has been done so far." ▪ Leader says, "Mary please start an IV." Mary responds, "Sorry, I do not know how, please ask someone else to do it."	▪ Event manager summarizes events. ▪ Event manager seeks additional information from all team members ▪ Event manager says, "Peter, I want you to get the defibrillator, we might have to shock this patient." Peter responds, "Yes, I know where it is and I'll get it."	

5. Team Support

The team works as a unit, asking for or offering assistance when needed vs. team members "going it alone."

	Lower Quality				Higher Quality	
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ No assistance or help asked for or offered ▪ Team members act unilaterally ▪ No recognition of mistakes ▪ Team members watching and not participating	▪ Team members take over when not needed ▪ Mistakes not addressed to the team ▪ Negative feedback	▪ Assistance is offered when needed only after multiple requests	▪ Team recognizes mistakes and constructively addresses them	▪ Team member(s) ask(s) for help when needed ▪ Assistance provided to team member(s) who need(s) it	
Examples	▪ During a shoulder dystocia event, the critical situation is recognized, but no help is requested or attempts to resolve situation on their own ▪ Wrong blood type delivered and administered, an no backup behaviors to correct the mistake ▪ Team member administers medication without consulting the event manager	▪ Charles knows that the patient is a Jehovah Witness and does not let the team know when a T&C is ordered. ▪ Team does not communicate that he/she doesn't know how to use a defibrillator and attempts to do it anyways and fails.	▪	▪	▪ During a shoulder dystocia event, the critical situation is recognized, and event manager calls for help ▪ Wrong blood type delivered, attempt made by team member to administer the blood but another team member recognizes the mistake and stops the transfusion before it starts ▪ Team member consults with the event manager before administering medication	

6. External Team Support

Work team provides “external team” (family members and / or other health care professionals) with information and support as needed

	Lower Quality				Higher Quality	
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Team fails to recognize or interact with other significant people who are present during the encounter	▪ Team recognizes other significant people who are present during the encounter but ignores to interact with them	▪ Team inconsistently interacts with other significant people who are present during the encounter	▪ Team interacts with other significant people who are present during the encounter	▪ Team effectively interacts with other significant people who are present during the encounter	
Examples	▪ Team fails to interact with a distraught family member and/or para-professional	▪ Team fails to interact appropriately with a distraught family member ▪ Team does not cooperate with a para-professional	▪	▪	▪	

7. Patient Support

Work team provides the patient and significant others with information and emotional support as needed.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Team fails to interact with patient if conscious ▪ Team fails to show empathy or respect for a patient (conscious or unconscious) ▪ Team fails to provide appropriate information when requested to do so	▪ Teams interaction with patient is minimal and when done so is lacking in respect or empathy	▪ Team inconsistently shows empathy or respect for a patient (conscious or unconscious) ▪ Team inconsistently provides information when requested to do so	▪ Team shows empathy toward patient ▪ Team provides appropriate information when requested to do so	▪ Team demonstrates consistent and significant respect and empathy for patient ▪ Appropriate information is provided consistently	
Examples	▪ Team deals with an unconscious patient with a lack of respect, e.g. by joking about his / her condition ▪ Charles knows that the patient is a Jehovah Witness and does not let the team know when a T&C is ordered.	▪	▪	▪ Charles lets the leader know that the patient is a Jehovah Witness and that she refused blood products.	▪	

8. Mutual Trust and Respect

The team demonstrates civility, courtesy and trust in collective judgment.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Team exhibits e.g. rudeness, overt distrust/mistrust, anger or overt doubt or suspicion toward each other	▪ Few team members exhibit rudeness, overt distrust, anger or suspicion toward each other	▪ Team inconsistently demonstrates respect, rudeness, distrust or anger toward each other	▪ Team exhibits e.g. civility, courtesy, and trust in collective judgment	▪ Team is significantly respectful of each other ▪ Praise when appropriate	
Examples	▪ Angry, stressed event manager says to team member, "I can't believe you can't intubate the patient. What's the matter with you?" ▪ Team member says to another, "You don't know what you're doing-let me do it for you." ▪ Event manager recognizes a chest tube is needed, and barks, "Michelle, I want you to put in a chest tube, I want you to do it now, and I want you to do it right on your first attempt."	▪ Leader overbearing and intimidating	▪	▪ Stressed but composed leader recognizes a team member cannot intubate the patient and offers assistance ▪ Team member says to another, "Are you OK? Let me know if I can help you." ▪ Event manager recognizes a chest tube is needed and says, "Michelle, this patient needs a chest tube-can you put it in now?"	▪ Leader is clear, direct, and calm. ▪ Team members will thank each other when appropriate.	

9. Flexibility

The team adapts to challenges, multitasks effectively, reallocates functions, and uses resources effectively; team self correction.

	Lower Quality			Higher Quality		
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Team rigidly adheres to individual team roles ▪ Inefficient resource allocation / use	▪ Minimal adaptability and/or hesitation to changing situations	▪ Team can adapt to certain situations, but not all	▪ Generally very flexible ▪ Multi-tasks effectively ▪ Reallocates functions ▪ Uses resources effectively	▪ Team adapts to challenges consistently ▪ Engages self-correction	
Examples	▪ Ambu-bag not working, and no reallocation of resources established ▪ Team members stay in individual roles, failing to support each other e.g. by failing to recognize fatigue of those giving CPR ▪ Patient's hysterical family member disrupts the team and team continues providing care, ignoring disruptive relative	▪	▪	▪ Ambu-bag not working, and an airway team member gives mouth-to-mouth with a mask and event manager asks another team member to retrieve a working ambu-bag ▪ Team members alternate giving CPR, recognizing fatigue of those giving CPR ▪ Patient's hysterical family member disrupts the team and a team manages the situation, e.g. removes, counsels, or reassures the family member	▪	

10. Overall Team Performance

	Lower Quality				Higher Quality	
Score	1	2	3	4	5	*CNE*
Level	*Limited*	*Basic*	*Progressing*	*Proficient*	*Advanced*	
Description	▪ Consistently operating at a novice training level	▪ Demonstrates inconsistent efforts to operate at a functional level	▪ Inconsistently demonstrates below and average attributes	▪ Demonstrates significant cohesiveness as a team unit; ▪ Performs proficiently	▪ Consistently operates at an experienced and professional level; performs as experts	
Training Level	▪ Team requires training at all levels; unable to function independently	▪ Team needs training at multiple levels to function independently	▪ Team needs focused training to function independently	▪ Team can function independently with supervision	▪ Team functions independently	

Case A – Dizziness, Acute

Student _____ **Student ID** _____ **SP ID** _____

History Scoring: Give students credit (**Yes**) if they ask any of the following questions and / or SPs give the following responses. If question(s) not asked or response(s) not give, give no credit (**No**).

	HISTORY CHECKLIST	Yes	No
1	ONSET, e.g. *"When did dizziness start?"* • "The dizziness started last night when I was cleaning up after dinner."		
2	PAST MEDICAL HISTORY OF PROBLEM, e.g. *"Ever had this problem before?"* ▪ "I almost passed out once in restaurant a few months ago. The EMT truck came and checked me out and they thought I was dehydrated from exercising. I had just come from the gym."		
3	QUALITY, e.g. *"Describe the dizziness."* • "Every few minutes or so I get the feeling the room is spinning and I feel a little nauseous, then it goes away and I feel OK. Then it starts all over again."		
4	AGGRAVATING, e.g. *"What makes the dizziness worse?"* ▪ "Standing up with my eyes open makes me feel dizzy."		
5	PALLIATIVE, *e.g.* "*What makes the dizziness better?"* ▪ "Closing my eyes and laying down makes the dizziness better."		
6	HEAD INJURIES, e.g. *"Have you bumped or injured your head?"* • "No head injuries."		
7	PAST MEDICAL HISTORY, e.g. *"How is your health in general?"* ▪ "In general I've been very healthy."		
8	MEDICATIONS, e.g. *"Are you taking any medications for this problem or anything else?"* ▪ "I'm not taking anything. I thought of taking Dramamine but I wasn't sure it would help."		
9	DIET, e.g. *"What do you eat in a typical day?"* ▪ "A regular diet, toast and coffee in the morning, usually take out for lunch, Chinese, a pizza or sub, something like that, and a regular meal at night."		
10	TOBACCO USE, e.g. *"Do you smoke?"* • "I used to smoke ½ a pack a day, but now I'm down to 4 or 5, sometimes a couple more if I'm stressed."		
11	ADLs, e.g. *"How is this affecting your life?"* ▪ "I couldn't go to work today."		

Case A – Dizziness, Acute

PE SCORING:

- **COLUMN 1: NO CREDIT:** If any box is checked, exam was done "incorrectly" or "incompletely." Checked "Incorrect Details" box records reason(s) why.
- **COLUMN 2: FULL CREDIT:** If "Correct" box is checked, exam was done "Correctly / Completely."
- **COLUMN 3: NO CREDIT:** If "Not Done" box is checked, exam was not attempted at all.

	Physical Examination Checklist	1 Incorrect Details	2 Correct	3 Not Done
12	**Perform fundoscopic examination**		□	□
	▪ Did not ask the patient to fix their gaze at point in front of them.	□		
	▪ Exam room not darkened.	□		
	▪ Otoscope used instead of ophthalmoscope	□		
	▪ "Left eye-left hand-left eye" or "right eye-right hand -right eye rule" not followed.	□		
	▪ Exam not bilateral.	□		
13	**Assess Cranial Nerve II – Optic - Assess Visual Fields by Confrontation**		□	□
	▪ Examiner not at approximate eye-level with patient, and / or no eye contact.	□		
	▪ Examiner's hands not placed outside of patient's field of vision.	□		
	▪ Did not ask "Tell me when you see my fingers."	□		
	▪ Did not test both upper <u>and</u> lower fields, and / or bilaterally.	□		
14	**Assess Cranial Nerves II and III – Optic and Oculomotor: Assess direct and consensual reactions**		□	□
	▪ Did not shine a light obliquely into each pupil *twice* to check both the *direct reaction* and *consensual reaction*.	□		
	▪ Did not assess bilaterally.	□		
15	**Assess Cranial Nerves II and III – Optic and Oculomotor: Assess near reaction and near response**		□	□
	▪ Did not test in normal room light.	□		
	▪ Finger, pencil, etc. placed too close or too far from the patient's eye.	□		
	▪ Did not ask the patient to look alternately at the finger or pencil and into the distance.	□		

Case A – Dizziness, Acute

PE SCORING:

- **COLUMN 1: NO CREDIT:** If any box is checked, exam was done "incorrectly" or "incompletely." Checked "Incorrect Details" box records reason(s) why.
- **COLUMN 2: FULL CREDIT:** If "Correct" box is checked, exam was done "Correctly / Completely."
- **COLUMN 3: NO CREDIT:** If "Not Done" box is checked, exam was not attempted at all.

		1 Incorrect Details	2 Correct	3 Not Done
16	**Assess Cranial Nerve III – Oculomotor: Assess convergence** ▪ Did not ask the patient to follow his / her finger or pencil as he / she moves it in toward the bridge of the nose.	□	□	□
17	**Assess Cranial Nerve III, IV and VI - Oculomotor, trochlear and abducens: Assessing extraocular muscle movement** ▪ Examiner did not assess extra-ocular muscle movements in <u>at least</u> 6 positions of gaze using, for example, the "H" pattern. ▪ Did not instruct patient to not move the head during the exam.	□ □	□	□
18	**Assess Cranial Nerve VIII – Acoustic / *Weber test*** ▪ Did not produce a sound from tuning fork, e.g. by not holding the fork at the base ▪ Did not place the base of the tuning fork firmly <u>on top middle</u> of the patient's head. ▪ Did not ask the patient where the sound appears to be coming from.	□ □ □	□	□
19	**Assess Cranial Nerve VIII – Acoustic / Rinne test** ▪ Did not produce a sound from tuning fork, e.g. by not holding the fork at the base ▪ Did not place the base of the tuning fork against the mastoid bone behind the ear. ▪ Did not ask patient to say when he / she no longer hears the sound, hold the end of the fork near the patient's ear and ask if he / she can hear the vibration. ▪ Did not tap again for the second ear. ▪ Did not assess bilaterally.	□ □ □ □ □	□	□
20	**Assess Gait** ▪ Did not ask patient to walk, turn and come back to look for imbalance, postural, asymmetry and type of gait (e.g. shuffling, walking on toes, etc.)	□	□	□
21	**Perform Romberg Test** ▪ Did not direct patient to stand with feet together, eyes closed, for *at least* 20 seconds without support. ▪ Did not stand in a supportive position, e.g. behind patient or with hand behind patient.	□ □	□	□

Case A – Dizziness, Acute

	RELATIONSHIP QUALITY To what degree did the student …	**Lower Quality**							**Higher Quality**
1	Establish and maintain rapport	1	2	3	4	5	6	7	8
2	Demonstrate empathy	1	2	3	4	5	6	7	8
3	Instill confidence	1	2	3	4	5	6	7	8
4	Use appropriate body language	1	2	3	4	5	6	7	8
	EXAMINATION QUALITY To what degree did the student …	**Lower Quality**							**Higher Quality**
5	Elicit information clearly, effectively	1	2	3	4	5	6	7	8
6	Actively listen	1	2	3	4	5	6	7	8
7	Provide timely feedback / information / counseling	1	2	3	4	5	6	7	8
8	Perform a thorough, careful physical exam or treatment	1	2	3	4	5	6	7	8

3. Clinical Clerkship Evaluations / NBOME Subject Exams

Data compiled from 3rd/4th year clerkships includes:

- ✓ Student Performance Evaluations from specific hospitals (attending/supervising physicians, and/or residents) based upon the 7 core Osteopathic Competencies. Data is broken down further by student cohort: traditional, BS/DO, and Émigré and is quantified according to curricular track (Lecture Discussion-Based and Doctor Patient Continuum);
- ✓ NBOME Subject Exam scores for each of the (6) core clerkships and OMM. Core clerkships include:

    a) Family Medicine
    b) Medicine
    c) OB-GYN
    d) Pediatrics
    e) Psychiatry
    f) Surgery

    NBOME Subject Exam statistics are shared with 3rd year students as a frame of reference to determine their performance relative to their NYCOM peers. These data also serve as a general guide for COMLEX II CE preparation and performance;
- ✓ Students provide feedback on their clinical experiences during their clerkships, via the "PDA project":

    a) The PDA is a tool utilized for monitoring clerkship activities. The DEALS (Daily Educational Activities Logs Submission) focuses on educational activities, while the LOG portion focuses on all major student-patient encounters. A rich data set is available for comparing patient encounters and educational activities across all sites for all clerkships.

b) PDA data is used as a multimodal quality assessment tool for curricular exposure as well as OMM integration across all hospitals (including "outside" clerkships) for Patient Encounters and Educational Activities.

- ✓ Reports from student focus groups—these reports are based upon in-person group interviews by a full-time NYCOM Medical Educator and feedback is analyzed in order to ensure consistency in clerkship education and experiences, as well as for program improvement indicators.

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- Clinical Clerkship Student Performance Evaluation

Samples of the forms/questionnaires follow

NEW YORK COLLEGE OF OSTEOPATHIC MEDICINE
OFFICE OF CLINICAL EDUCATION
Northern Boulevard –- Old Westbury, NY 11568-8000
Tel.: 516-686-3718 - Fax: 516-686-3833

(*) Only ONE form, with COMPOSITE GRADE & COMMENTS should be sent to the Hospital's Office of Medical Education for the DME SIGNATURE.

COURSE # _____(For NYCOM Purpose ONLY)

STUDENT: _____,_____Class Year: _____HOSPITAL:_____
Last First

ROTATION(Specialty)_____ROTATION DATES: ____/____/____ ____/____/____
From To

EVALUATOR: _____ TITLE: _____
(Attending Physician / Faculty Preceptor)

A. Student logs by PDA ☐ REVIEWED (at least 10 patients) ☐ NOT REVIEWED

B. Student's unique "STRENGTHS" (Very Important --To be incorporated into the College's Dean's Letter)

_____
_____
_____
_____
_____
_____
_____

C. Student's LIMITATIONS (areas requiring special attention for future professional growth)

_____
_____
_____
_____

D. For items below CIRCLE the most appropriate number corresponding to the following rating scale:

Exceptional=5	Very Good = 4	Average = 3	Marginal = 2	1 = FAILURE	N/A OR no opportunity to observe

CORE COMPETENCY (See definitions on reverse side)							RATING
Patient Care	5	4	3	2	1	N	/A
Medical Knowledge	5	4	3	2	1	N	/A
Practice-Based Learning & Improvement	5	4	3	2	1	N	/A
Professionalism	5	4	3	2	1	N	/A
System-Based Practice	5	4	3	2	1	N	/A
Interpersonal and Communication Skills	5	4	3	2	1	N/A	
Osteopathic Manipulative Medicine	5	4	3	2	1	N	/A

OVERALL RADG	5	4	3	2	1 (FAILURE

Evaluator Signature:_____ **Date:** _____/_____/_____

Student Signature: _____ **Date:** _____/_____/_____
(Ideally at Exit Conference)

(*) DME Signature: _____ **Date:** _____/_____/_____

Please Return to: → Hospital's Office of Medical Education

OVER →

The Seven Osteopathic Medical Competencies

Physician Competency is a measurable demonstration of suitable or sufficient knowledge, skill sets, experience, values, and behaviors, that meet established professional standards, supported by the best available medical evidence, that are in the best interest of the well-being and health of the patient.

Patient Care: Osteopathic patient care is the ability to effectively determine and monitor the nature of a patient's concern or problem; to develop, maintain, and to bring to closure the therapeutic physician-patient relationship; to appropriately incorporate osteopathic principles, practices and manipulative treatment; and to implement effective diagnostic and treatment plans, including appropriate patient education and follow-up, that are based on best medical evidence.

Medical Knowledge: **Medical Knowledge is the understanding and application of biomedical, clinical, epidemiological, biomechanical, and social and behavioral sciences in the context of patient-centered care.**

Practice-Based Learning & Improvement: **Practice-Based learning and improvement is the continuous evaluation of clinical practice utilizing evidence-based medicine approaches to develop best practices that will result in optimal patient care outcomes.**

Professionalism: **Medical professionalism is a duty to consistently demonstrate behaviors that uphold the highest moral and ethical standards of the osteopathic profession. This includes a commitment to continuous learning and the exhibition of personal and social accountability. Medical professionalism extends to those normative behaviors ordinarily expected in the conduct of medical education, training, research, and practice.**

System-Based Practice: **System-based practice is an awareness of and responsiveness to the larger context and system of health care, and the ability to effectively identify and integrate system resources to provide care that is of optimal value to individuals and society at large.**

Interpersonal & Communication Skills: **Interpersonal and communication skills are written, verbal, and non-verbal behaviors that facilitate understanding the patient's perspective. These skills include building the physician-patient relationship, opening the discussion, gathering information, empathy, listening, sharing information, reaching agreement on problems and plans, and providing closure. These skills extend to communication with patients, families, and members of the health care team.**

Osteopathic Manipulative Medicine: **Osteopathic philosophy is a holistic approach that encompasses the psychosocial, biomedical, and biomechanical aspects of both health and disease, and stresses the relationship between structure and function, with particular regard to the musculoskeletal system.**

Definitions Provided by the National Board of Osteopathic Medical Examiners (NBOME)

4. Student feedback (assessment) of courses / Clinical clerkship / PDA project

- ✓ Data received on courses and faculty through the newly implemented, innovative Course / Faculty Assessment program (see below-NYCOM Student Guide for Curriculum and Faculty Assessment). Students (randomly) assigned (by teams) to evaluate one course (and associated faculty) during 2-year pre-clinical curriculum. Outcome of student-team assessment is presented to Curriculum Committee, in the form of a one-page Comprehensive Report;
- ✓ Clerkship Feedback (quantitative and "open-ended" feedback) provided through "Matchstix" (web-based feedback program): this information is shared with NYCOM Deans and Clinical Chairs, Hospital Director's of Medical Education (DMEs), Hospital Department Chairs and Clerkship Supervisors. Also, the information is posted on the "web" to assist and facilitate 2nd year students choosing 3rd year Core Clerkship Sites (transparency). This data is also utilized via two (2) year comparisons of quantitative data and student feedback shared with NYCOM Deans & Chairs, as well as Hospital DMEs;
- ✓ Clerkship Feedback via PDA: quantitative and open-ended (qualitative) feedback on all clerkships is collected via student PDA submission. The information is utilized as a catalyst for clerkship quality enhancement. This data-set is used as a multimodal quality assessment tool for curricular exposure as well as OMM integration across all hospitals (including "outside" clerkships) for Patient Encounters and Educational Activities;

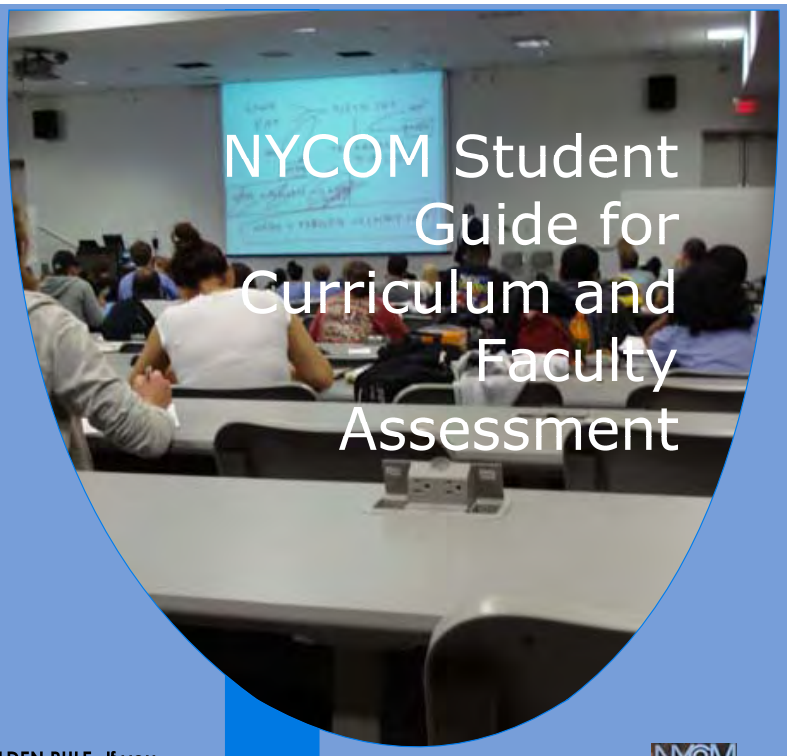
- ✓ Reports from student focus groups—these reports are based upon in-person group interviews by a full-time NYCOM Medical Educator and feedback is analyzed in order to ensure consistency in clerkship education and experiences, as well as for program improvement indicators;

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- NYCOM Student Guide for Curriculum and Faculty Assessment
- Clerkship (site) feedback from Clerkship students
- Clinical Clerkship Focus Group Form
- 4th Year PDA Feedback Questionnaire
- Student End-of-Semester Program Evaluations (DPC)
- DPC Program Assessment Plan
- Osteopathic Manipulative Medicine (OMM) Assessment Forms

Samples of the forms/questionnaires follow

NYCOM Student Guide for Curriculum and Faculty Assessment



The New Curriculum/Faculty Assessment Plan

What's in it for NYCOM students?

- Students will assess only one course during their two years of pre-clinical study.
- Student assessments will be compiled into a final Consensus Report which will be presented at the Round Table and the Curriculum Committee meetings.
- Students will be empowered to offer specific suggestions and remedies to issues related to curriculum and faculty.

THE GOLDEN RULE- If you identify an issue, then offer a recommendation for a solution.

Medical professionalism is a set of values, attitudes, and behaviors that result in serving the interests of patients and society before one's own. Professionalism involves making a commitment and getting involved.

- ***Your Course/Faculty assessment team will select a group leader.***
- ***Your assessments will be brief (1-2 pages), written with professional language.***
- ***Participation in team assignments is fully expected.***
- ***Attendance at team meetings is required.***

THE GOLDEN RULE- If you identify an issue, then offer a recommendation for a solution.

Your Course Director and Curriculum/Faculty Assessment (CFA) Advisor:

- The Course Director will speak to your CFA team and maintain an open door policy for questions or assistance.
- The CFA Advisor will be assigned to your group to assist with technical questions and organization of your group.
- The CFA Advisor participates with the CFA team, only to offer assistance, not write the assessment for students.

Site Feedback

Rotation: Surgery

Site: (*) MAIMONIDES MEDICAL CENTER

This is an anonymous feedback form. No student identification data is transmitted.

Questions marked with * are mandatory.

Section I. Please respond to each statement in this section according to the following scale.

STRONGLY DISAGREE <-> STRONGLY AGREE

1* *There were adequate learning opportunities (teaching patients, diversity of pathology and diagnostic procedures)*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

2* *There were opportunities to practice osteopathic diagnosis and therapy*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

3* *There was adequate supervision and feedback (e.g., reviews of my H&P, progress notes and clinical skills)*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

4* *I had the opportunity to perform procedures relevant for my level of training*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

5* *I was evaluated fairly for my level of knowledge and skills*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

6* *Attending physicians and/or house staff were committed to teaching*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

7* *Overall, I felt meaningfully engaged and well integrated with the clinical teams (e.g., given sufficient patient care responsibilities)*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

8* *The DME and/or clerkship director was responsive to my needs as a student*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

9* *There were adequate library resources at this facility*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

10* *A structured program of directed readings and/or journal club was a component of this rotation.*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

11* *The lectures were appropriate for this rotation (e.g., quality, quantity and relevance of topics)*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

12* *Educationally useful teaching rounds were conducted on a regular basis.*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

13* *This rotation reflected a proper balance of service and education*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

14* *This rotation incorporated a psychosocial component in patient care*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

15* *Overall, I would recommend this rotation to others*

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

---

Section II. Psychomotor skills

Indicate the number you performed on an average week during this rotation for each of the following:

16* *History and Physicals*

☐

17* *Osteopathic structural examinations*

18* *Osteopathic Manipulative Treatments*

19* *Starting IVs*

20* *Venipunctures*

21* *Administering injections*

22* *Recording notes on medical records*

23* *Reviewing X-Rays*

24* *Reviewing EKGs*

25* *Urinary catherizations*

26* *Insertion and removal of sutures*

27* *Minor surgical procedures (assist)*

28* *Major surgical procedures (assist)*

29* *Care of dressings and drains*

30* *Sterile field maintenance*

Section III

31* *Comment on unique STRENGTHS and Positive Features of this rotation*

32* *Comment on the LIMITATIONS and Negative Features of this rotation*

33* *Comment on the extent in which the Learning Objectives for the rotation were met (e.g., specific topics/patient populations to which you were or not exposed)*

Section IV. Please list your clinical instructors with whom you had substantial contact on this rotation and provide a general rating of their effectiveness as Teachers using the scale below.

5=EXCELLENT, 4=VERY GOOD, 3=AVERAGE, 2=BELOW AVERAGE, 1=POOR
For example - John Smith - 4

34* *List clinical instructors and rating in the box below*

To submit your feedback, enter your password below and then click on Submit Feedback button

Submit Feedback Cancel

Focus Groups on Clinical Clerkships

NAME OF HOSPITAL:

LOCATION:

DATE OF SITE VISIT:

The student's comments on the clinical rotations are as follows:

(Name of Clerkship)

STRENGHTS:

WEAKNESSES:

4th Year PDA Feedback Questionnaire

1. Clinic Site
2. Rotation
3. Date
4. There were adequate learning opportunities
5. There were opportunities to practice Osteopathic diagnosis & therapy
6. I was evaluated fairly for my level of knowledge and skills
7. Attending physicians and/or house staff were committed to teaching
8. Overall, I felt meaningfully engaged and well integrated with the clinical teams
9. The DME and/or clerkship director was responsive to my needs as a student
10. This rotation reflected a proper balance of service and education
11. Overall, I would recommend this clerkship to others
12. Comments
13. Strengths/Positive Features of Rotation
14. Limitations/Negative Features of Rotation
15. List and Rate Clinical Instructors

Student End-of-Semester Program Evaluations

The DPC Student End-of-Semester Program Evaluation is an assessment of each course that occurred during the semester and the corresponding faculty members.

DPC END OF SEMESTER EVALUATION

Directions:

1. Please write in your year of graduation here:_____.

2. Enclosed you will find a blank scantron sheet.

3. Please make sure that you are using a #2 pencil to fill in your answers.

4. Please fill in the following Test Form information on the Scantron Sheet:
   - DPC Class 2011 – Bubble in Test Form A
   - DPC Class 2012 – Bubble in Test Form B

5. No other identifying information is necessary.

6. Please complete each of the following numbered sentences throughout this evaluation using the following responses:

   A. Excellent – couldn't be better
   B. Good – only slight improvement possible
   C. Satisfactory – about average
   D. Fair – some improvement needed
   E. Poor – considerable improvement needed

7. There are spaces after each section in which you can write comments.

(When making comments, please know that your responses will be shared with DPC faculty, Dept. chairs, and deans, as part of ongoing program evaluation.)

BIOPSYCHOSOCIAL SCIENCES COURSE EVALUATION:

I. CASE STUDIES COMPONENT

		Excellent	Good	Satis-factory	Fair	Poor
1.	This course, overall is	A	B	C	D	E
2.	My effort in this course, overall is	A	B	C	D	E
3.	The case studies used in small group are	A	B	C	D	E
4.	My preparation for each group session was	A	B	C	D	E
5.	Other available resources for use in small group are	A	B	C	D	E
6.	Facilitator assessments are	A	B	C	D	E
7.	Self assessments are	A	B	C	D	E
8.	Content Exams – midterm and final are	A	B	C	D	E
9.	The group process in my group can be described as	A	B	C	D	E
10.	The wrap-ups in my group were	A	B	C	D	E
11.	The quality of the learning issues developed by my group was	A	B	C	D	E

Overall comments on Case Studies

II. STUDENT HOUR COMPONENT:

		Excellent	Good	Satis-factory	Fair	Poor
12.	The monthly student hours are	A	B	C	D	E

Overall Comments On The Student Hour

III. FACILITATOR RATINGS

Please circle your group number/the name of your group facilitator(s).

Group	Facilitators
A	Dr. _____ and Dr. _____
B	Dr. _____ and Dr. _____
C	Dr. _____ and Dr. _____
D	Dr. _____ and Dr. _____

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
13.	Maintained appropriate directiveness	5 (A)	4 (B)	2 (C)	1 (D)
14.	Supported appropriate group process	5 (A)	4 (B)	2 (C)	1 (D)
15.	Supported student-directed learning	5 (A)	4 (B)	2 (C)	1 (D)
16.	Gave appropriate feedback to group	5 (A)	4 (B)	2 (C)	1 (D)
17.	Ensured that learning issues were Appropriate	5 (A)	4 (B)	2 (C)	1 (D)
18.	Overall, these facilitators were effective	5 (A)	4 (B)	2 (C)	1 (D)

Overall Facilitator Comments
(Comments on individual facilitators are welcome)

IV. PROBLEM SETS/DISCUSSION SESSIONS COMPONENT

A. Course Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
19.	These sessions, overall were	A	B	C	D	E
20.	My effort in these sessions, overall was	A	B	C	D	E
21.	The organization of these sessions was	A	B	C	D	E
22.	Handouts in general were	A	B	C	D	E

Problem Sets/Discussion Sessions Comments
(Please comment as to whether problem sets were too many, too few, too involved.)

V. PROBLEM SETS/DISCUSSION SESSIONS COMPONENT

B. Presenter Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
23.	The Problem Set topic on _____was	A	B	C	D	E
24.	The instructor,_____ _____, for the problem set named in #23 was	A	B	C	D	E
25.	The Problem Set topic on _____was	A	B	C	D	E
26.	The instructor,_____ _____, for the problem set named in #25 was	A	B	C	D	E
27.	The Problem Set topic on _____was	A	B	C	D	E
28.	The instructor,_____ _____, for the problem set named in #27 was	A	B	C	D	E
29.	The Problem Set topic on _____was	A	B	C	D	E
30.	The instructor,_____ _____, for the problem set named in #29 was	A	B	C	D	E
31.	The Problem Set topic on _____was	A	B	C	D	E
32.	The instructor,_____ _____, for the problem set named in #31 was	A	B	C	D	E

Problem Sets/Discussion Sessions Comments
(Comments on individual instructors are welcome)

VI. ANATOMY COMPONENT

A. Course Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
33.	This component, overall was	A	B	C	D	E
34.	My effort in this component was	A	B	C	D	E
35.	My preparation for each lab session was	A	B	C	D	E
36.	Organization of the component was	A	B	C	D	E
37.	Quizzes were	A	B	C	D	E
38.	Resource Hour / Reviews were	A	B	C	D	E

Anatomy Component Comments

VII. ANATOMY COMPONENT

B. Teaching Evaluation:

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
39.	The faculty were available to answer questions in the lab	5 (A)	4 (B)	2 (C)	1 (D)
40.	The faculty Initiated student discussion	5 (A)	4 (B)	2 (C)	1 (D)
41.	The faculty were prepared for each lab session	5 (A)	4 (B)	2 (C)	1 (D)
42.	The faculty gave me feedback on how I was doing	5 (A)	4 (B)	2 (C)	1 (D)
43.	The faculty were enthusiastic about the course	5 (A)	4 (B)	2 (C)	1 (D)
44.	Overall, the instructors were effective	5 (A)	4 (B)	2 (C)	1 (D)

Anatomy Component Comments
(Comments on individual instructors are welcome)

CLINICAL SCIENCES COURSE

I. CLINICAL SKILLS LAB COMPONENT

A. Course Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
45.	This component, overall was	A	B	C	D	E
46.	My effort in this component was	A	B	C	D	E
47.	My preparation for each lab session was	A	B	C	D	E
48.	Organization of the component was	A	B	C	D	E
49.	Examinations were	A	B	C	D	E
50.	Handouts/PowerPoints were	A	B	C	D	E
51.	I would rate my physical exam and history taking skills at this time to be	A	B	C	D	E

Overall Comments on Clinical Skills Component / Individual Labs
(Comments on individual instructors are welcome)

I. CLINICAL SKILLS LAB COMPONENT

B. Teaching Evaluation:

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
52.	The faculty were available to answer questions in the lab	5 (A)	4 (B)	2 (C)	1 (D)
53.	The faculty initiated student discussion	5 (A)	4 (B)	2 (C)	1 (D)
54.	The faculty were prepared for each lab session	5 (A)	4 (B)	2 (C)	1 (D)
55.	The faculty Gave me feedback on how I was doing	5 (A)	4 (B)	2 (C)	1 (D)
56.	The faculty were enthusiastic about the course	5 (A)	4 (B)	2 (C)	1 (D)
57.	Overall, the instructors were effective	5 (A)	4 (B)	2 (C)	1 (D)

Overall Comments on Clinical Skills Component / Individual Labs
(Comments on individual instructors are welcome)

II. OMM COMPONENT

A. Course Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
58.	This component, overall was	A	B	C	D	E
59.	My effort in this component was	A	B	C	D	E
60.	My preparation for each lab session was	A	B	C	D	E
61.	Organization of the component was	A	B	C	D	E
62.	Presentations / Lectures were	A	B	C	D	E
63.	Handouts were	A	B	C	D	E
64.	Quizzes were	A	B	C	D	E
65.	Practical exams were	A	B	C	D	E
66.	Resource Hour / Reviews were	A	B	C	D	E

Overall Comments on OMM Component / Individual Labs
(Comments on individual instructors are welcome)

II. OMM COMPONENT

B. Teaching Evaluation

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
67.	The faculty were available to answer questions in the lab	5 (A)	4 (B)	2 (C)	1 (D)
68.	The faculty Initiated student discussion	5 (A)	4 (B)	2 (C)	1 (D)
69.	The faculty were prepared for each lab session	5 (A)	4 (B)	2 (C)	1 (D)
70.	The faculty gave me feedback on how I was doing	5 (A)	4 (B)	2 (C)	1 (D)
71.	The faculty were enthusiastic about the course	5 (A)	4 (B)	2 (C)	1 (D)
72.	Overall, the instructors were effective	5 (A)	4 (B)	2 (C)	1 (D)

Overall Comments on OMM Component / Individual Labs
(Comments on individual instructors are welcome)

III. ICC COMPONENT

A. Course Evaluation:

		Excellent	Good	Satis-factory	Fair	Poor
73.	This component, overall was	A	B	C	D	E
74.	My effort in this component was	A	B	C	D	E
75.	My preparation for each lab session was	A	B	C	D	E
76.	Organization of this component was	A	B	C	D	E
77.	The helpfulness/usefulness of the ICC standardized patient encounters was	A	B	C	D	E
78.	The helpfulness/usefulness of the ICC robotic patient encounters was	A	B	C	D	E
79.	Are Clinical Skills laboratory exercises appropriate for the ICC? [A] YES [B] NO	A YES	B NO	-	-	-

Overall Comments on the ICC Component
(Comments on individual instructors are welcome)

IV. CLINICAL PRACTICUM COMPONENT

80. I participated in Clinical Practicum this semester: [A] YES [B] NO

If you answered NO to this question, you have finished this evaluation, if you answered YES, please continue this questionnaire until the end. Thank you.

A. Course Evaluation

		Excellent	Good	Satis-factory	Fair	Poor
81.	This component, overall was	A	B	C	D	E
82.	My effort in this component was	A	B	C	D	E
83.	My preparation for each lab session was	A	B	C	D	E
84.	Organization of this component was	A	B	C	D	E
85.	The helpfulness/usefulness of the Clinical Practicum was	A	B	C	D	E
86.	The organization of the case presentations was	A	B	C	D	E
87.	Are Clinical Skills laboratory exercises appropriate for the Clinical Practicum?	A YES	B NO	-	-	-

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
88.	The case presentation exercise was a valuable learning experience	5 (A)	4 (B)	2 (C)	1 (D)

Overall Comments on Clinical Practicum Course

IV. CLINICAL PRACTICUM COMPONENT

B. Mentor Evaluation:

Please bubble in your response to each of the following items:

		Strongly Agree	Agree	Disagree	Strongly Disagree
89.	The preceptor was available to answer my questions	5 (A)	4 (B)	2 (C)	1 (D)
90.	I was supported in my interaction with patients	5 (A)	4 (B)	2 (C)	1 (D)
91.	Student-directed learning was supported	5 (A)	4 (B)	2 (C)	1 (D)
92.	I had appropriate feedback	5 (A)	4 (B)	2 (C)	1 (D)
93.	Overall, this preceptor/site was effective	5 (A)	4 (B)	2 (C)	1 (D)

Preceptor Name _____

Overall Comments on Clinical Practicum Mentor
(Comments on individual instructors are welcome)

DPC: Program Assessment Plan

I. **Pre matriculated Evaluation** – What determines that an applicant will pick the DPC program?

- Comparison of the students who chose the LDB program vs. the DPC program with regard to the following outcome measures:
  - GPA scores (overall, science)
  - MCAT scores
  - Gender
  - Age
  - Race
  - College size
  - College Geographic location
  - Prior PBL exposure
  - OMM understanding
  - Research Background
  - Volunteer Work
  - Employment Experience
  - Graduate Degree
  - Scholarships/Awards

II. **Years at NYCOM** – How do we evaluate if the DPC program is accomplishing its goals while the students are at NYCOM?

- Comparison of Facilitator Assessments for each term, to monitor student growth
- Comparison of Clinical Practicum Mentor Evaluations from Term 2 and Term 3, to evaluate the student's clinical experience progress
- Comparison of Content exam scores from terms 1 through 4.
- Comparison of entrance questionnaire (administered during first week of medical school) responses to corresponding exit questionnaire administered at the end of year 4
- Evaluation of the Student DPC End-of-Term Evaluations
- Comparison of the following measures to those outcomes achieved by the students in the LDB program:
  - OMM scores

- Anatomy scores
- ICC PARS scores
- ICC OSCE scores
- Summer research
- Summer Volunteerism
- Research effort (publications, abstracts, posters, presentations)
- Shelf-exams
- COMLEX I, II, III scores and pass rate
- Fellowships (Academic, Research)

III. **Post Graduate Training Practice** – What happens to the DPC student once they leave NYCOM? How to they compare to those students who matriculated through the LDB program?

- Comparison of the following measures to those outcomes achieved by the students in the LDB program:
  - Internships
  - Residencies
  - Fellowships
  - Specialty (medicine)
  - Specialty board certifications
  - AOA membership
  - AMA membership
  - Publications
  - Research
  - Teaching

Stanley Schiowitz, D.O., F.A.A.O. Department of Osteopathic Manipulative Medicine
Student Evaluation of Lab

Date:_____ Time:_____
Lecturer:_____ Evaluator:_____
(name optional)

Instructions:

1. Form may be signed if you wish.
2. Circle the number that best corresponds to your opinion (differing scales).
3. Add comments below if you like, or explain your numeric choices.
4. Please return to an OMM fellow or faculty member after the lecture.

Demonstrations and use of visual aides	Poor 1	2	3	4	5	6	7	8	9	Excellent 10
Time allowed to practice	Not Enough 1	2	3	4	5	6	7	8	9	Too Much 10
Amount of Material	Too Little 1	2	3	4	5	6	7	8	9	Too Much 10
Complexity of Material	Too Simple 1	2	3	4	5	6	7	8	9	Too Complex 10
Organization of the lab	Poor 1	2	3	4	5	6	7	8	9	Excellent 10
Voice Modulation	Poor 1	2	3	4	5	6	7	8	9	Excellent 10
Relation of lab material to reading assignments	Poor 1	2	3	4	5	6	7	8	9	Excellent 10

Strong points of the lab:

Stanley Schiowitz, D.O., F.A.A.O. Department of Osteopathic Manipulative Medicine
Student Evaluation of Lecture

Date:_____ Time:_____
Lecturer:_____ Evaluator:_____
(name optional)

Instructions:

1. Form may be signed if you wish.
2. Circle the number that best corresponds to your opinion (differing scales).
3. Add comments below if you like, or explain your numeric choices.
4. Please return to an OMM fellow or faculty member after the lecture.

Use of Audiovisuals	Poor									Excellent
	1	2	3	4	5	6	7	8	9	10
Presentation Speed	Too Slow									Too Fast
	1	2	3	4	5	6	7	8	9	10
Amount of Material	Too Little									Too Much
	1	2	3	4	5	6	7	8	9	10
Complexity of Material	Too Simple								Too Complex	
	1	2	3	4	5	6	7	8	9	10
Organization of the lecture	Poor									Excellent
	1	2	3	4	5	6	7	8	9	10
Voice Modulation	Poor									Excellent
	1	2	3	4	5	6	7	8	9	10
Relation of lecture material to reading assignments	Poor									Excellent
	1	2	3	4	5	6	7	8	9	10

Strong points of the lecture:

Comments and suggestions to make the lecture more useful:

5. COMLEX USA Level I, Level II CE & PE, and Level III data (NBOME)

a) First-time and overall pass rates and mean scores;

b) Comparison to national averages;

c) Comparison to college (NYCOM) national ranking.

- Report provided by Associate Dean for Academic Affairs

6. Residency match rates and overall placement rate

Data compiled as received from the American Osteopathic Association (AOA) and the National Residency Match Program (NRMP).

- Report provided by Associate Dean for Clinical Education

7. Feedback from (AACOM) Graduation Questionnaire

Annual survey report received from AACOM comparing NYCOM graduates responses to numerous questions/categories (including demographics, specialty choice, overall perception of pre-doctoral training, indebtedness, and more) to nation-wide osteopathic medical school graduating class responses.

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- AACOM Survey of Graduating Seniors

Samples of the forms/questionnaires follow

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE
2007-08 Academic Year Survey of Graduating Seniors

TO THE STUDENTS: **Your opinions and attitudes about your medical education, your plans for medical practice, and information about your debt are very important as the colleges and the osteopathic profession develop and plan for the future of osteopathic medical education. Please take some time to complete the following questionnaire to help in planning the future of osteopathic medical education. The information you provide in this survey will be reported only in aggregate or summary form; individually identifiable information will not be made available to the colleges. The reason we ask for your identification is to allow for longitudinal studies linking your responses when you took a similar survey as a first-year medical student to your responses as a graduating medical student.**

Please fill in marks like this: ●

Please print in Capital Letters:

Last Name _ Suffix _ _ _

First Name _ _ _ _ _ _ _ _ _ _ _ _ _ Middle Name _ _ _ _ _ _ _ _ _ _ _ _ _

or Maiden Name if Married Woman Using Husband's Name

Osteopathic College

O ATSU-SOMA	O LECOM-Bradenton	O OU-COM	O UMDNJ-SOM
O ATSU/KCOM	O LECOM-PA	O PCOM	O UNECOM
O AZCOM	O LMU-DCOM	O PCSOM	O UNTHSC/TCOM
O CCOM	O MSUCOM	O TOUROCOM	O VCOM
O DMU-COM	O NSU-COM	O TUCOM-CA	O WesternU/COMP
O GA-PCOM	O NYCOM	O TUNCOM	O WVSOM
O KCUMB-COM	O OSU-COM		

Part I: OPINIONS

O1. Instruction. Please evaluate the amount of instruction provided in each of the areas listed below. Please note, this item concludes on the next page. Use the scale below.

(1) Appropriate *(2) Inadequate* *(3) Excessive*

a.	Basic medical science	① ② ③	l.	Cost-effective medical practice	① ② ③
b.	Behavioral science	① ② ③	m.	Diagnostic skills	① ② ③
c.	Biostatistics	① ② ③	n.	Drug and alcohol abuse	① ② ③
d.	Bioterrorism	① ② ③	o.	Family/domestic violence	① ② ③
e.	Care of ambulatory patients	① ② ③	p.	Genetics	① ② ③
f.	Care of elderly (geriatrics)	① ② ③	q.	Health promotion & disease prevention	① ② ③
g.	Care of hospitalized patients	① ② ③	r.	Human sexuality	① ② ③
h.	Care of patients with HIV/AIDS	① ② ③	s.	Independent learning & self-evaluation	① ② ③
i.	Clinical decision-making	① ② ③	t.	Infection control/health care setting	① ② ③
j.	Clinical pharmacology	① ② ③	u.	Infectious disease prevention	① ② ③
k.	Clinical science	① ② ③	v.	Integrative medicine	① ② ③

(1) Appropriate *(2) Inadequate* *(3) Excessive*

w.	Legal medicine	① ② ③	ii.	Physician-patient relationship	① ② ③
x.	Literature analysis skill	① ② ③	jj.	Practice management	① ② ③
y.	Medical care cost control	① ② ③	kk.	Primary care	① ② ③
z.	Medical ethics	① ② ③	ll.	Public health & community medicine	① ② ③
aa.	Medical record-keeping	① ② ③	mm.	Rehabilitation	① ② ③
bb.	Medical socioeconomics	① ② ③	nn.	Research techniques	① ② ③
cc.	Neuromusculoskeletal medicine/OMT	① ② ③	oo.	Role of medicine in community	① ② ③
dd.	Nutrition	① ② ③	pp.	Screening for diseases	① ② ③
ee.	Pain management	① ② ③	qq.	Teamwork with other health professionals	① ② ③
ff.	Patient education	① ② ③	rr.	Therapeutic management	① ② ③
gg.	Patient follow-up	① ② ③	ss.	Use of computers	① ② ③
hh.	Patient interviewing skills	① ② ③	tt.	Utilization review & quality assurance	① ② ③

O2. Please rate your overall satisfaction with the quality of your medical education.

O a. Very satisfied O b. Satisfied O c. Neither satisfied nor dissatisfied O d. Dissatisfied O e. Very dissatisfied

O3. Using the following scale, please indicate how confident you are in your ability to perform the following examinations: Use the scale below.

(1) Completely Confident *(2) Mostly Confident* *(3) Fairly Confident*
(4) Somewhat Confident *(5) Not At All Confident* *(6) No Opportunity to Perform*

a.	General adult examination	① ② ③ ④ ⑤ ⑥
b.	General pediatric examination	① ② ③ ④ ⑤ ⑥
c.	Well-baby examination	① ② ③ ④ ⑤ ⑥
d.	Breast and pelvic examination	① ② ③ ④ ⑤ ⑥
e.	Prostate and testicular examination	① ② ③ ④ ⑤ ⑥
f.	Osteopathic structural examination	① ② ③ ④ ⑤ ⑥
g.	Sports participation examination	① ② ③ ④ ⑤ ⑥

O4. Please indicate whether you agree or disagree with the following statements about your first two years of medical education. Use the scale below.

(1) Strongly Agree *(2) Agree* *(3) Disagree* *(4) Strongly Disagree* *(5) No Opinion*

a.	Basic & clinical science course objectives were made clear to students	① ② ③ ④ ⑤
b.	Basic science courses were sufficiently integrated with each other	① ② ③ ④ ⑤
c.	Basic science courses were sufficiently integrated with clinical training	① ② ③ ④ ⑤
d.	Course objectives & examination content matched closely	① ② ③ ④ ⑤
e.	Course work adequately prepared students for clerkships	① ② ③ ④ ⑤
f.	The first two years of medical school were well organized	① ② ③ ④ ⑤
g.	Students were provided with timely feedback on performance	① ② ③ ④ ⑤
h.	There was adequate exposure to patient care during the first two years	① ② ③ ④ ⑤
i.	Osteopathic principles were adequately integrated into course work	① ② ③ ④ ⑤
j.	An appropriate amount of training was provided in OMT	① ② ③ ④ ⑤
k.	There was adequate preparation for COMLEX Level I	① ② ③ ④ ⑤

O5. a. Please indicate whether you agree or disagree with the following statements about your *Required Clerkships* during the last two years of medical education. Please use the scale below.

(1) Strongly Agree (2) Agree (3) Disagree (4) Strongly Disagree (5) No Opinion

1.	Clear goals and objectives were set	① ② ③ ④ ⑤
2.	I was able to design own goals and objectives	① ② ③ ④ ⑤
3.	Clear performance objectives were set	① ② ③ ④ ⑤
4.	Clerkships were well-organized	① ② ③ ④ ⑤
5.	Rounds were conducted as scheduled	① ② ③ ④ ⑤
6.	Timely feedback was provided on performance	① ② ③ ④ ⑤
7.	There was too large a role by residents in teaching and evaluation	① ② ③ ④ ⑤
8.	There was appropriate diversity of patients and their health issues	① ② ③ ④ ⑤
9.	There was an appropriate number of inpatient experiences	① ② ③ ④ ⑤
10.	Each clerkship had an osteopathic orientation	① ② ③ ④ ⑤
11.	Osteopathic principles & practice (OPP) were well-integrated in each clerkship	① ② ③ ④ ⑤
12.	There was appropriate technology usage for situation	① ② ③ ④ ⑤
13.	I was able to work on a personal basis with patients	① ② ③ ④ ⑤
14.	The attending modeled excellent patient relationship skills	① ② ③ ④ ⑤
15.	Support staff was friendly and supportive	① ② ③ ④ ⑤
16.	Coverage hours were set and finished on time	① ② ③ ④ ⑤
17.	I was asked relevant and pertinent questions on patient diagnosis, treatment options, management, and follow-up care	① ② ③ ④ ⑤
18.	I felt free to ask questions	① ② ③ ④ ⑤
19.	The attending seemed interested in my opinions	① ② ③ ④ ⑤
20.	Personal concerns were addressed by the attending while on rotation	① ② ③ ④ ⑤
21.	I was treated with respect	① ② ③ ④ ⑤
22.	I was able to discuss progress on rotation with attending	① ② ③ ④ ⑤
23.	The attending critically evaluated me during rotation	① ② ③ ④ ⑤
24.	I was able to discuss the final rotation evaluation with the attending	① ② ③ ④ ⑤
25.	The attending based the evaluation on direct observation	① ② ③ ④ ⑤
26.	I was able to meet & discuss areas of concern with the attending outside of the clinical setting	① ② ③ ④ ⑤
27.	I lived a reasonable distance from rotation sites	① ② ③ ④ ⑤
28.	The rotations prepared me for examinations	① ② ③ ④ ⑤
29.	Testing was provided at end of each clerkship	① ② ③ ④ ⑤
30.	There was adequate preparation for COMLEX Level 2-CE	① ② ③ ④ ⑤
31.	There was adequate preparation for COMLEX Level 2-PE	① ② ③ ④ ⑤

b. Please indicate whether you agree or disagree with the following statements about your *Selective/Elective Clerkships* during the last two years of medical education. Please note, this item concludes on the next page. Please use the scale below.

(1) Strongly Agree (2) Agree (3) Disagree (4) Strongly Disagree (5) No Opinion

1.	Clear goals and objectives were set	① ② ③ ④ ⑤
2.	I was able to design own goals and objectives	① ② ③ ④ ⑤
3.	Clear performance objectives were set	① ② ③ ④ ⑤

(1) Strongly Agree (2) Agree (3) Disagree (4) Strongly Disagree (5) No Opinion

4.	Clerkships were well-organized	①	②	③	④	⑤
5.	Rounds were conducted as scheduled	①	②	③	④	⑤
6.	Timely feedback was provided on performance	①	②	③	④	⑤
7.	There was too large a role by residents in teaching and evaluation	①	②	③	④	⑤
8.	There was appropriate diversity of patients and their health issues	①	②	③	④	⑤
9.	There was an appropriate number of inpatient experiences	①	②	③	④	⑤
10.	Each clerkship had an osteopathic orientation	①	②	③	④	⑤
11.	Osteopathic principles & practice (OPP) were well-integrated in each clerkship	①	②	③	④	⑤
12.	There was appropriate technology usage for situation	①	②	③	④	⑤
13.	I was able to work on a personal basis with patients	①	②	③	④	⑤
14.	The attending modeled excellent patient relationship skills	①	②	③	④	⑤
15.	Support staff was friendly and supportive	①	②	③	④	⑤
16.	Coverage hours were set and finished on time	①	②	③	④	⑤
17.	I was asked relevant and pertinent questions on patient diagnosis, treatment options, management, and follow-up care	①	②	③	④	⑤
18.	I felt free to ask questions	①	②	③	④	⑤
19.	The attending seemed interested in my opinions	①	②	③	④	⑤
20.	Personal concerns were addressed by the attending while on rotation	①	②	③	④	⑤
21.	I was treated with respect	①	②	③	④	⑤
22.	I was able to discuss progress on rotation with attending	①	②	③	④	⑤
23.	The attending critically evaluated me during rotation	①	②	③	④	⑤
24.	I was able to discuss the final rotation evaluation with the attending	①	②	③	④	⑤
25.	The attending based the evaluation on direct observation	①	②	③	④	⑤
26.	I was able to meet & discuss areas of concern with the attending outside of the clinical setting	①	②	③	④	⑤
27.	I lived a reasonable distance from rotation sites	①	②	③	④	⑤
28.	The rotations prepared me for examinations	①	②	③	④	⑤
29.	Testing was provided at end of each clerkship	①	②	③	④	⑤
30.	There was adequate preparation for COMLEX Level 2-CE	①	②	③	④	⑤
31.	There was adequate preparation for COMLEX Level 2-PE	①	②	③	④	⑤

O6. a. How was your osteopathic medical school involved in your third- and fourth-year education? Check all that apply.

O 1. COMLEX Level 2-CE preparation
O 2. COMLEX Level 2-PE preparation
O 3. Distance learning
O 4. E-mail
O 5. Faculty visit
O 6. Newsletter

b. In your view how appropriate was your osteopathic medical school involvement in your clerkship years?

O 1. Excessive involvement
O 2. Outstanding involvement
O 3. Adequate involvement
O 4. Some, but inadequate involvement
O 5. Not involved

O7. Indicate your level of satisfaction with the following. Please use the scale below.

(1) Very Satisfied (2) Satisfied (3) Dissatisfied (4) Very Dissatisfied (5) No Opinion

a.	Academic counseling	① ② ③ ④ ⑤
b.	Accessibility to administration	① ② ③ ④ ⑤
c.	Awareness of student problems by administration	① ② ③ ④ ⑤
d.	Career counseling	① ② ③ ④ ⑤
e.	Computer resource center	① ② ③ ④ ⑤
f.	Disability insurance	① ② ③ ④ ⑤
g.	Electronic communication (e-mail, Internet/Intranet)	① ② ③ ④ ⑤
h.	Faculty mentoring	① ② ③ ④ ⑤
i.	Financial aid administration services	① ② ③ ④ ⑤
j.	Library	① ② ③ ④ ⑤
k.	Participation of students on key medical school committees	① ② ③ ④ ⑤
l.	Personal counseling	① ② ③ ④ ⑤
m.	Student health insurance	① ② ③ ④ ⑤
n.	Student health services	① ② ③ ④ ⑤
o.	Student relaxation space	① ② ③ ④ ⑤
p.	Student study space	① ② ③ ④ ⑤
q.	Tutorial help	① ② ③ ④ ⑤

O8. Please estimate the percentage of time you devoted to the following activities during the third and fourth years. Please be sure the sum equals 100%. Please note: this item concludes on the next page.

a. Inpatient care, including reading x-ray films & laboratory work

b. Outpatient care

c. Extended/long-term care

d. Research

a.	b.	c.	d.
_ _ _ %	_ _ _ %	_ _ _ %	_ _ _ %
⓪ ⓪ ⓪	⓪ ⓪ ⓪	⓪ ⓪ ⓪	⓪ ⓪ ⓪
① ① ①	① ① ①	① ① ①	① ① ①
ⓞ ② ②	ⓞ ② ②	ⓞ ② ②	ⓞ ② ②
ⓞ ③ ③	ⓞ ③ ③	ⓞ ③ ③	ⓞ ③ ③
ⓞ ④ ④	ⓞ ④ ④	ⓞ ④ ④	ⓞ ④ ④
ⓞ ⑤ ⑤	ⓞ ⑤ ⑤	ⓞ ⑤ ⑤	ⓞ ⑤ ⑤
ⓞ ⑥ ⑥	ⓞ ⑥ ⑥	ⓞ ⑥ ⑥	ⓞ ⑥ ⑥
ⓞ ⑦ ⑦	ⓞ ⑦ ⑦	ⓞ ⑦ ⑦	ⓞ ⑦ ⑦
ⓞ ⑧ ⑧	ⓞ ⑧ ⑧	ⓞ ⑧ ⑧	ⓞ ⑧ ⑧
ⓞ ⑨ ⑨	ⓞ ⑨ ⑨	ⓞ ⑨ ⑨	ⓞ ⑨ ⑨

O8e. Other, please specify

_____

_ _ _ %

⓪ ⓪ ⓪
① ① ①
· ② ②
· ③ ③
· ④ ④
· ⑤ ⑤
· ⑥ ⑥
· ⑦ ⑦
· ⑧ ⑧
· ⑨ ⑨

O9. At this time, how satisfied are you that you selected *osteopathic* medicine as a career?

O a. Very satisfied
O b. Satisfied
O c. Mixed feelings
O d. Dissatisfied
O e. Very dissatisfied

O10. If given the opportunity to begin your medical education again, would you prefer to enroll in:

O a. The osteopathic medical school from which you are about to graduate
O b. Another osteopathic medical school
O c. An allopathic medical school
O d. Would not have gone to medical school at all

O11. Please indicate your agreement with the following statements regarding your training in Osteopathic Manipulative Treatment, Principles and Practice. Please use the scale below.
(1) Strongly agree (2) Agree (3) Neither agree nor disagree (4) Disagree (5) Strongly disagree

a.	Well prepared to diagnose structural problems	① ② ③ ④ ⑤
b.	Well prepared to treat structural problems	① ② ③ ④ ⑤
c.	Well prepared to document findings in a structural examination	① ② ③ ④ ⑤
d.	Had opportunity to practice OPP during first two years in medical school	① ② ③ ④ ⑤
e.	Had opportunity to practice OPP during in-hospital rotations	① ② ③ ④ ⑤
f.	Had opportunity to practice OPP during ambulatory primary care rotations	① ② ③ ④ ⑤
g.	Had opportunity to practice OPP during ambulatory non-primary care rotations	① ② ③ ④ ⑤
h.	Had osteopathic physician role models during the first two years in medical school	① ② ③ ④ ⑤
i.	Had osteopathic physician role models during required in-hospital rotations	① ② ③ ④ ⑤
j.	Had osteopathic physician role models during ambulatory primary care rotations	① ② ③ ④ ⑤
k.	Had osteopathic physician role models during ambulatory non-primary care rotations	① ② ③ ④ ⑤
l.	Had osteopathic physician role models during selectives/electives	① ② ③ ④ ⑤

O12. What percentage of your training was delivered by allopathic physicians?

		None	1 – 25%	26-50%	51-75%	76-100%
a.	During the first two years of medical school	O	O	O	O	O
b.	During required in-hospital rotations	O	O	O	O	O
c.	During required ambulatory primary care rotations	O	O	O	O	O
d.	During required ambulatory non-primary care rotations	O	O	O	O	O
e.	During selectives/electives	O	O	O	O	O

O13. Please use as much of this page as you wish to submit suggestions for improvement or positive comments on your medical education. Your comments will be fed back to the schools absolutely ANONYMOUSLY in the spirit of helping to improve osteopathic medical education. **Please print or write legibly.**

Part II: CAREER PLANS

P1. Plans Upon Graduation: Please indicate what type of osteopathic internship you plan to do. (Choose only one.)

O a. Traditional rotating

O b. Special emphasis — Indicate type:

1.	Anesthesiology	O	2.	Diagnostic Radiology	O
3.	Emergency Med.	O	4.	Family Practice	O
5.	General Surgery	O	6.	Psychiatry	O

O c. Specialty track — Indicate type:

1.	Internal Medicine	O	2.	Internal Medicine/Peds.	O
3.	Ob/Gyn	O	4.	Otolaryn./Facial Plastic Surg.	O
5.	Pediatrics	O	6.	Urological Surgery	O

O d. Pursue AOA/ACGME dual approved internship

O e. Not planning osteopathic internship. Reason:

1. Allopathic residency O
2. Other O

Please specify _____

O f. Undecided

P2. a. Immediate Post-Internship Residency Plans: Select the ***one*** item that best describes your plans immediately after internship *(or upon graduation if not planning an osteopathic internship).*

O 1. Pursue osteopathic residency
O 2. Pursue allopathic residency **(see Item P2b)**
O 3. Pursue AOA/ACGME dual approved residency **(see Item P2b)**
O 4. Enter governmental service (*e.g.,* military, NHS Corps, Indian Health Service, V.A., state/local health dept.) **(see Item P2b)**

If you are not doing a residency, please indicate your post-internship plans.

O 5. Practice in an HMO
O 6. Self-employed with or without a partner
O 7. Employed in group or other type of private practice (salary, commission, percentage)
O 8. Other professional activity (*e.g.,* teaching, research, administration, fellowship)
O 9. Undecided or indefinite post-graduation/internship plans

b. If you plan to pursue an allopathic or AOA/ACGME dual approved residency, please give *all* the reasons that apply to you.

O 1. Desire specialty training not available in osteopathic program
O 2. Believe better training and educational opportunities available
O 3. Located in more suitable geographic location(s)
O 4. Located in larger institutions
O 5. Better chance of being accepted in program
O 6. Allow ABMS Board certification
O 7. Opens more career opportunities
O 8. Military or government service obligation
O 9. Shorter training period
O 10. Higher pay
O 11. Other, please specify _____

P3. Long-Range Plans: Select the ***one*** item that best describes your intended activity five years ***after*** internship and residency training.

O 1. Enter governmental service (*e.g.,* military, NHS Corps, Indian Health Service, V.A., state/local health dept.)
O 2. Practice in an HMO
O 3. Self-employed with or without a partner
O 4. Employed in group or other type of private practice (salary, commission, percentage)
O 5. Other professional activity (*e.g.,* teaching, research, administration, fellowship)
O 6. Undecided or indefinite

P4. a. Area of Interest: Select *one* specialty in which you are most likely to work or seek training.

- O 1. Family Practice
- O 2. General Internal Medicine
- O 3. Internal Medicine Subspecialty
- O 4. Osteopathic Manip. Ther. & Neuromusculoskeletal Med.
- O 5. General Pediatrics
- O 6. Pediatrics Subspecialty
- O 7. Allergy and Immunology
- O 8. Anesthesiology
- O 9. Critical Care
- O 10. Dermatology
- O 11. Emergency Medicine
- O 12. Geriatrics
- O 13. Medical Genetics
- O 14. Neurology including subspecialties
- O 15. Psychiatry including subspecialties
- O 16. Nuclear Medicine
- O 17. Ob/Gyn including subspecialties
- O 18. Ophthalmology
- O 19. Otolaryngology
- O 20. Pathology including subspecialties
- O 21. Physical Medicine & Rehabilitation Med.
- O 22. Preventive Medicine including subspec.
- O 23. Proctology
- O 24. Radiology (Diagnostic) including subspec.
- O 25. Sports Medicine
- O 26. General Surgery
- O 27. Orthopedic Surgery
- O 28. Surgery, subspecialty
- O 29. Vascular Surgery
- O 30. Urology/Urological Surgery
- O 31. Undecided or Indefinite

b. Please select *one* item that best describes your plans for board certification.

- O 1. AOA Boards (osteopathic)
- O 2. ABMS Boards (allopathic) **(see Item P4c)**
- O 3. Both boards **(see Item P4c)**
- O 4. Other, please specify _____
- O 5. Not planning board certification
- O 6. Undecided or indefinite

c. If you selected ABMS or both boards in item P4b, please indicate *all* the reasons for your choice.

- O 1. ABMS board certification is more widely recognized
- O 2. ABMS board certification has more colleague acceptance
- O 3. ABMS board certification carries more prestige
- O 4. ABMS board certification provides more opportunities (career, residencies, etc.)
- O 5. Personal desire for dual certification
- O 6. Hospital privileges more readily obtained with ABMS board certification.
- O 7. Licenses more readily obtained with ABMS board certification
- O 8. Other, please specify

_____

P5. Please indicate the importance of each of the following factors affecting your specialty choice decision. Use the scale below.

(1) Major Influence (2) Strong Influence (3) Moderate Influence (4) Minor Influence (5) No Influence/NA

a.	Intellectual content of the specialty (type of work, diagnostic programs, diversity)	(1) (2) (3) (4) (5)
b.	Like dealing with people (type of person, type of patient) more than techniques	(1) (2) (3) (4) (5)
c.	Prestige/income potential	(1) (2) (3) (4) (5)
d.	Lifestyle (predictable working hours, sufficient time for family)	(1) (2) (3) (4) (5)
e.	Like the emphasis on technical skills	(1) (2) (3) (4) (5)
f.	Role models (*e.g.*, physicians in the specialty)	(1) (2) (3) (4) (5)
g.	Peer influence (encouragement from practicing physicians, faculty, or other students)	(1) (2) (3) (4) (5)
h.	Skills/abilities (possess the skills required for the specialty or its patient population)	(1) (2) (3) (4) (5)
i.	Debt level (level of debt, length of residency, high malpractice insurance premiums)	(1) (2) (3) (4) (5)
j.	Academic environment (courses, clerkships in the specialty area)	(1) (2) (3) (4) (5)
k.	Opportunity for research/creativity	(1) (2) (3) (4) (5)
l.	Desire for independence	(1) (2) (3) (4) (5)
m.	Previous experience	(1) (2) (3) (4) (5)

P6. Answer only ONE item.

a. State (two-letter abbreviation) where you expect to locate after completion of internship and residency?

b. Fill in if non-U.S. O

c. Fill in if unknown/undecided O

P7. a. What is the population of the city/town/area of legal residence where you plan to be employed or in practice after completion of internship or residency?

1. Major metropolitan area (1,000,001 or more) O
2. Metropolitan area (500,001 – 1,000,000) O
3. City (100,001 – 500,000) O
4. City (50,001 – 100,000) O
5. City or town (10,001 – 50,000) O
6. City or town (2,501 – 10,000) O
7. Town under 2,500 O
8. Other, please specify O

   _____

9. Undecided or indefinite O

b. Are you planning to practice in any underserved or shortage areas? Yes O No O Unsure O

P8. Expected Income: What annual net income do you expect to earn before taxes during:

a. First year in practice after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

b. Fifth year after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

c. Tenth year after internship and residency?

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

Part III: Financial Aid

A1. Undergraduate College Debt: If none, enter zero.

a. **At entry** how much did you owe from undergraduate college or other postgraduate education?

$ _ _ _ , _ _ _

b. How much do you **expect to** owe on undergraduate college or other postgraduate education debt in **A1a** at graduation? (Exclude osteopathic medical school debt; that is covered in **A2.**)

$ _ _ _ , _ _ _

A2. Osteopathic Medical School Indebtedness: Indicate the principal amount you borrowed from each loan source listed below to finance your osteopathic medical education through graduation from osteopathic college. Exclude loans for your undergraduate or previous postgraduate education **(see Item A1)** and non-educational debt **(see Item A6)**. Please answer **TOTAL (A2j)** even if you don't know the breakout of individual loans.

a. Unsubsidized Stafford or unsubsidized Federal Family Education Loan Program (FFELP). **If none, enter zero.**

$ _ _ _ , _ _ _

b. Subsidized Stafford Loan Program or FFELP. **If none, enter zero.**

$ _ _ _ , _ _ _

c. Perkins Loan. **If none, enter zero.**

$ _ _ _ , _ _ _

A2d. Loans for Disadvantaged Students (LDS). **If none, enter zero.**

$ _ _ _ , _ _ _

e. Primary Care Loan (PCL). **If none, enter zero.**

$ _ _ _ , _ _ _

f. Other loan insured by a state government. **If none, enter zero.**

$ _ _ _ , _ _ _

g. Osteopathic association loans (AOA, state or local osteopathic society). **If none, enter zero.**

$ _ _ _ , _ _ _

h. Alternative loan (Robert Wood Johnson Foundation, student loan program, PEP, StillLoan, MedFunds, CitiAssist, MedEXCEL, Med-Cap, Med-Achiever, Signature Health). **If none, enter zero.**

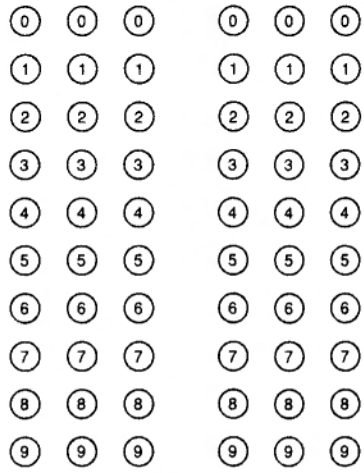
$ _ _ _ , _ _ _

A2i. Other personal loans in your name. **If none, enter zero.**

$ _ _ _ , _ _ _

j. TOTAL. If none, enter zero.

$ _ _ _ , _ _ _



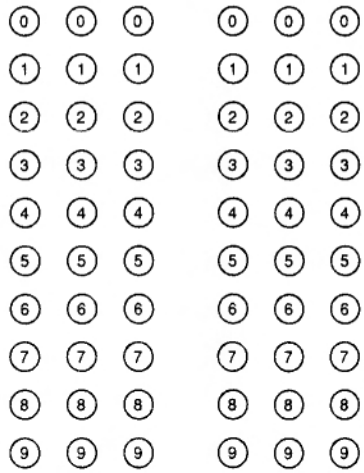
A3. Family Loans (omit any scholarships and loans in your name (see Item A2i): If your parents or other family members borrowed to help finance your osteopathic education, please indicate the total amount of their loan(s).

a. Total loans taken out by family members. **If none, enter zero.**

$ _ _ _ , _ _ _

b. Amount of family loans in A3a to be repaid by you. **If none, enter zero.**

$ _ _ _ , _ _ _



A4. Scholarships and grants for Medical Education: Indicate the total amount you received as scholarsip/grant, fellowship funds from the sources listed below to finance your osteopathic medical education. **Exclude any scholarships or grants received to finance your undergraduate or previous postgraduate education.** Please answer **TOTAL (A4h)** even if you don't know the breakout of individual scholarships/grants, fellowships.

a. National Health Service Corps Scholarship. **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

b. Armed Forces Health Professions Scholarship. **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

c. State government Scholarship/-grant. **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

d. Scholarship/grant/fellowship from osteopathic school or its parent university (*e.g.*. EFN, FADHPS, SDS). **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

e. Tuition waiver. **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

f. Osteopathic association scholarships (AOA, state or local osteopathic society). **If none, enter zero.**

$ _ _ _ , _ _ _

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

A4g. Other sources (*e.g.*, IHS). **If none, enter zero.**

$ _ _ _ , _ _ _

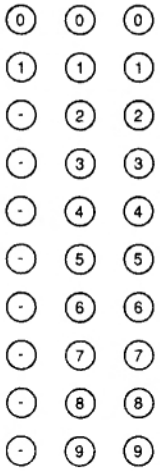
h. TOTAL. If none, enter zero.

$ _ _ _ , _ _ _

A5. Estimate the percentage of total cost of your medical education that was paid by each of the following sources. Please be sure the sum of A5a through A5g equals 100%.

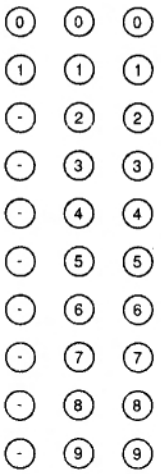
a. Loans (from **Items A2 & A3b**)

_ _ _ %



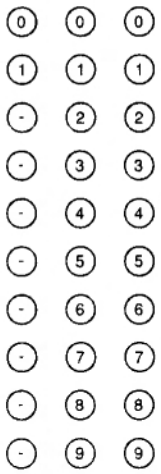
b. Scholarships or grants (from **Item A4**)

_ _ _ %



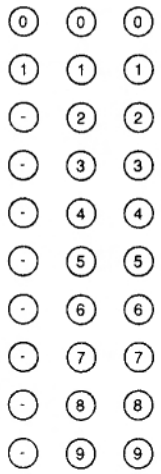
c. Your savings

_ _ _ %

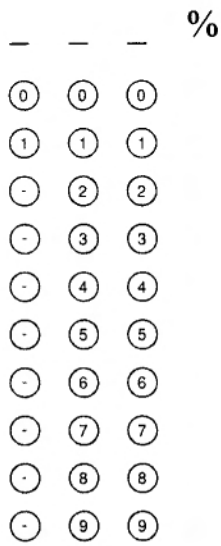


d. Earnings (including spouse's)

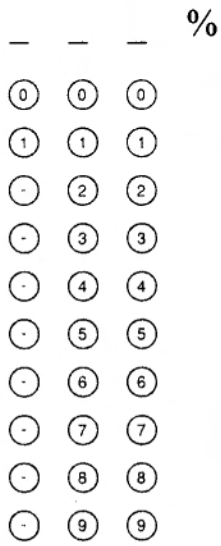
_ _ _ %



A5e. Parents

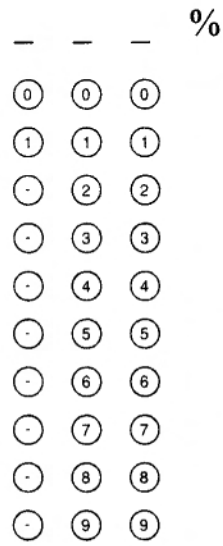


f. Other relatives

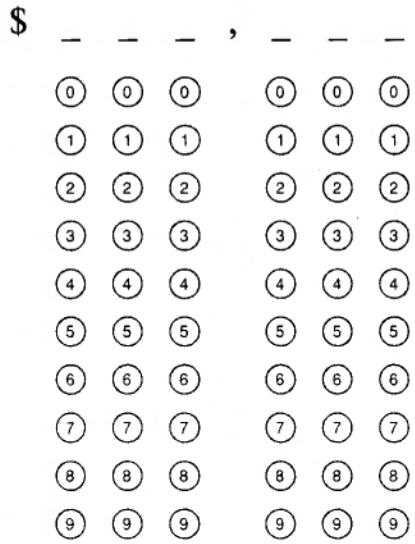


g. Other, specify

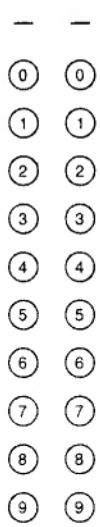
_____



A6. Non-educational Debts You Incurred While in Medical School: Show the total amount of non-educational school debt (such as car loans, credit cards, medical expenses, and living expenses) that you incurred during medical school. Do not include your home mortgage in this figure. **If none, enter zero.**



A7a. How many years do you expect to take to repay the indebtedness for your osteopathic education?



b. Do you anticipate participating in a student loan consolidation program for repayment?

O Yes

O No

O Undecided

Part IV: DEMOGRAPHIC DATA

This information is for classification purposes only and is considered confidential. *Information will only be used by AACOM and affiliated organizations in totals or averages.*

D1. Date of Birth __ __ / __ __ / __ __ **D2.** Sex: Male O Female O **D3.** Marital Status: Married/cohabiting O Single/other O

D4. SSN __ __ __ - __ __ - __ __ __ __

AACOM asks for your Social Security Number so that we can track data longitudinally—a similar survey is administered on matriculation, and this number allows us to analyze changes in responses. AACOM provides reports to the COMs only in aggregate and does not include any individual identifiers.

D5. Dependents: Including yourself, how many dependents do you support financially?

1	2	3	4	5 or more
O	O	O	O	O

D6. Ethnic background: Indicate your ethnic identification from the categories below. Please mark all that apply.

a.	Black/African American	O	h.	Chinese	O	n.	Indian/Pakistani	O
b.	American Indian/Alaskan Native	O	i.	Filipino	O	o.	Other Pacific Islander	O
c.	White	O	j.	Hawaiian	O	p.	Southeast Asian (non-Vietnamese)	O
d.	Mexican American/Chicano	O	k.	Korean	O	q.	Other Asian	O
e.	Puerto Rican (Mainland)	O	l.	Vietnamese	O	r.	Other, specify	O
f.	Puerto Rican (Commonwealth)	O	m.	Japanese	O			
g.	Other Hispanic	O						

_____

D7. Citizenship Status: U.S. O Permanent Resident O Other O Please specify _____

D8. State of Legal Residence: Use 2 letter postal abbreviation. __ __

D9. Population of city/town/area of legal residence:

a.	Major metropolitan area (1,000,001 or more)	O	e.	City or town (10,001 – 50,000)	O
b.	Metropolitan area (500,001 – 1,000,000)	O	f.	City or town (2,501 – 10,000)	O
c.	City (100,001 – 500,000)	O	g.	Town under 2,500	O
d.	City (50,001 – 100,000)	O	h.	Other	O

Please specify _____

D10. a. Father's Education: Select the **highest** level of education your father attained. Complete this item even if he is deceased.

1.	Professional Degree (DO/MD, JD, DDS, etc.) (See Item D10b below)	O	4.	Bachelor's	O
			5.	Associate Degree/Technical Certificate	O
2.	Doctorate (Ph.D., Ed.D., etc.)	O	6.	High School Graduate	O
3.	Master's	O	7.	Less than High School	O

b. If your father's **professional** degree is in the Health Professions field, please select one of the following:

DO/MD O Other O

D11. a. Mother's Education: Select the **highest** level of education your mother attained. Complete this item even if she is deceased.

1. Professional Degree (DO/MD, JD, DDS, etc.) (See Item D11b below)	O	4. Bachelor's	O
		5. Associate Degree/Technical Certificate	O
2. Doctorate (Ph.D., Ed.D., etc.)	O	6. High School Graduate	O
3. Master's	O	7. Less than High School	O

b. If your mother's **professional** degree is in the Health Professions field, please select one of the following:

DO/MD O Other O

D12. Parents' Income: Give your best estimate of your parents' combined income before taxes for the prior year.

a. Less than $20,000	O	d. $50,000 - $74,999	O	g. $200,000 or more	O
b. $20,000 - $34,999	O	e. $75,000 - $99,999	O	h. Deceased/Unknown	O
c. $35,000 - $49,999	O	f. $100,000 - $199,999	O		

D13. Financial Independence: Do you consider yourself financially independent from your parents? Yes O No O

Thank you very much for your cooperation!
AACOM congratulates you on your upcoming graduation from osteopathic medical school and wishes you all the best in your career as an osteopathic physician.

8. Completion rates (post-doctoral programs)

Percent of NYCOM graduates completing internship/residency training programs.

- Report provided by Office of Program Evaluation and Assessment

9. Specialty certification and licensure

Data compiled from state licensure boards and other specialty certification organization (board certification) on NYCOM graduates.

- Report provided by Office of Program Evaluation and Assessment

10. Career choices and geographic practice location

Data includes practice type (academic, research, clinical, and so on) and practice location. Data obtained from licensure boards, as well as NYCOM Alumni survey.

- Report provided by Office of Program Evaluation and Assessment

11. Alumni Survey

Follow up survey periodically sent to alumni requesting information on topics such as practice location, specialty, residency training, board certification and so on.

Specific forms/questionnaires utilized to capture the above-detailed information include the following:

- Alumni Survey

Samples of the forms/questionnaires follow

NEW YORK COLLEGE OF OSTEOPATHIC MEDICINE
OF NEW YORK INSTITUTE OF TECHNOLOGY

ALUMNI SURVEY

NAME LAST FIRST NYCOM CLASS YEAR
HOME ADDRESS
PRACTICE ADDRESS
HOME PHONE ( ) OFFICE PHONE ( )
E-MAIL ADDRESS
_____ _____ _____ INTERNSHIP HOSPITAL RESIDENCY HOSPITAL FIELD OF STUDY
FELLOWSHIPS COMPLETED:
CERTIFICATIONS YOU HOLD:
IF SPOUSE IS ALSO A NYCOM ALUMNUS, PLEASE INDICATE SPOUSE'S NAME AND CLASS YEAR:
EXCLUDING INTERNSHIP, RESIDENCY AND FELLOWSHIP, HAVE YOU EARNED ANY ADDITIONAL ACADEMIC DEGREES OR CERTIFICATES BEYOND YOUR MEDICAL DEGREE (I.E., MPH, MBA, MHA, PHD, MS)? (PLEASE LIST)
CURRENT PRACTICE STATUS: FULL-TIME PRACTICE___ PART-TIME PRACTICE _____ INTERN/RESIDENCY _____ RETIRED/NOT PRACTICING _____

What specialty do you practice most frequently? *(Choose one)*

- ❑ Allergy and Immunology
- ❑ Anesthesiology
- ❑ Cardiology
- ❑ Colorectal Surgery
- ❑ Dermatology
- ❑ Emergency Medicine
- ❑ Endocrinology
- ❑ Family Practice
- ❑ Gastroenterology
- ❑ Geriatrics
- ❑ Hematology
- ❑ Infectious Diseases
- ❑ Internal Medicine
- ❑ Neruology
- ❑ Neonatology
- ❑ Nephrology
- ❑ Neurology
- ❑ Nuclear Medicine
- ❑ Obstetrics & Gynecology
- ❑ Occupational Medicine
- ❑ Ophthalmology
- ❑ Oncology
- ❑ Otolaryngology
- ❑ Orthopedic Surgery
- ❑ Psychiatry
- ❑ Pediatrics
- ❑ Plastic/Recon. Surgery
- ❑ Physical Medicine/Rehab
- ❑ Pathology
- ❑ Pulmonary Medicine
- ❑ Radiology
- ❑ Rheumatology
- ❑ Surgery (general)
- ❑ Thoracic Surgery
- ❑ Radiation Therapy
- ❑ Urology
- ❑ Other *(Please specify)*

_____

Current military status (if applicable):

- ❑ Active Duty
- ❑ Inactive reserve
- ❑ Active Reserve

What is the population of the geographic area of your practice*?* *(Choose one)*

- ❑ 5,000,000 +
- ❑ 1,000,000 – 4,999,999
- ❑ 500,000 – 999,999
- ❑ 250,000 – 499,999
- ❑ 100,000 – 249,999
- ❑ 50,000 – 99,999
- ❑ 25,000 – 49,999
- ❑ 10,000 – 24,999
- ❑ 5,000 – 9,999
- ❑ Less than 5,000

How would you describe this geographic area? (Choose one)

- ❑ Inner City
- ❑ Urban
- ❑ Suburban
- ❑ Small Town - Rural
- ❑ Small town - industrial

Other _____

What functions do you perform in your practice? (check all that apply)

- ❑ Preventive care/patient education
- ❑ Acute care
- ❑ Routine/non-acute care
- ❑ Consulting
- ❑ Supervisory/managerial responsibilities
- ❑ Research
- ❑ Teaching
- ❑ Hospital Rounds

What best describes the setting in which you spend the most time ?

- ❑ Intensive Care Unit of Hospital
- ❑ Inpatient Unit of Hospital (not ICU/CCU)
- ❑ Outpatient Unit of Hospital
- ❑ Hospital Emergency Room
- ❑ Hospital Operating Room
- ❑ Freestanding Urgent Care Center
- ❑ Freestanding Surgical Facility
- ❑ Nursing Home or LTC Facility
- ❑ Solo practice physician office
- ❑ Single Specialty Group practice physician office
- ❑ Multiple Specialty Group practice physician office
- ❑ University Student Health facility
- ❑ School-based Health center
- ❑ HMO facility
- ❑ Rural Health Clinic
- ❑ Inner-city Health Center
- ❑ Other Community Health Center
- ❑ Other Freestanding Outpatient facility
- ❑ Correctional facility
- ❑ Industrial facility
- ❑ Mobile Health Unit
- ❑ Other *(Please specify)*

_____

Do you access medical information via the internet ?

- ❑ Never
- ❑ Sometimes
- ❑ Often

What percent of your time is spent in primary care? (family medicine or gen. internal medicine)

- ❑ 0%
- ❑ 1 - 25%
- ❑ 25 - 50%
- ❑ 50 - 75%
- ❑ 75 - 100%

What percent of your practice is outpatient?

- ❑ 0%
- ❑ 1 - 25%
- ❑ 25 - 50%
- ❑ 50 - 75%
- ❑ 75 - 100%

Do you engage in any of the following activities? (check all that apply)

- ❑ Professional organization leadership position
- ❑ Volunteer services in the community
- ❑ School or team physician
- ❑ Free medical care
- ❑ Leadership in church, congregation
- ❑ Local government
- ❑ Speaking on medical topics to community groups

How many CME programs or other professional training sessions did you attend last year?

- ❑ none
- ❑ 1-5
- ❑ 5-10
- ❑ 10-15
- ❑ more than 15

Have you ever done any of the following?

- ❑ Author or co-author a professional paper
- ❑ Contribute to an article
- ❑ Direct a research project
- ❑ Participate in clinical research
- ❑ Present a lecture at a professional meeting or CME program
- ❑ Serve on a panel discussion at a professional meeting

How often do you read medical literature regarding new research findings?

- ❑ Rarely
- ❑ Several times a year
- ❑ Monthly
- ❑ Weekly
- ❑ Daily

How frequently do you apply osteopathic concepts into patient care?

- ❑ Never
- ❑ Rarely
- ❑ Often
- ❑ Always

In your practice do you employ any of the following?
(check all that apply)

- ❑ Structural examination or musculoskeletal considerations in diagnosis
- ❑ Indirect OMT techniques
- ❑ High Velocity OMT
- ❑ Myofascial OMT
- ❑ Cranial OMT
- ❑ Palpatory diagnosis

Please indicate how important each of the following skills has been in your success as a physician, and how well NYCOM prepared you in that skill.	**How important to my practice**	**How well NYCOM prepared me**
Biomedical science knowledge base	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Clinical skills	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Patient educator skills	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Empathy and compassion for patients	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Understanding of cultural differences	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Osteopathic philosophy	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Clinical decision making	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Foundation of ethical standards	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Ability to communicate with other health care providers	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Ability to communicate with patients and families	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Knowing how to access community resources	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Ability to understand and apply new medical information	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Understanding of the payor/reimbursement system	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak

Ability to search and retrieve needed information	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Manipulative treatment skill	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Ability to use medical technology	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Diagnostic skill	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Skill in preventive care	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Understanding of public health issues & the public health system	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak
Professionalism	☐Strong ☐ Moderate ☐Weak	☐Strong ☐ Moderate ☐Weak

Please return to:

NYCOM of NYIT, Office of Alumni Affairs
Northern Boulevard, Serota Bldg., Room 218
Old Westbury, New York 11568

or

fax to (516) 686-3891 or (516) 686-3822
as soon as possible.

Thank you for your cooperation!

NYCOM Benchmarks

1-Applicant Pool
Benchmark: To maintain relative standing among Osteopathic Medical Colleges based on the number of applicants.

2-Admissions Profile
Benchmark: Maintain or improve current admissions profile based on academic criteria such as MCAT, GPA, or Colleges attended.

3-Academic Attrition Rates
Benchmark: To maintain or improve our current 3% Academic Attrition rate

4-Remediation rates (pre-clinical years)
Benchmark: A 2% a year reduction in the students remediating in pre-clinical years.

5-COMLEX USA Scores
Benchmark: Top quartile in the National Ranking of 1st time pass rate and Mean Score.

6-Students entering Osteopathic Graduate Medical Education (OGME)
Benchmark: Maintain or improve the current OGME placement.

7-Graduates entering Primary Care (PC) [12]
Benchmark: Maintain or improve the current Primary Care placement**.**

8-Career Data -Licensure (within 3 years, post-graduate), Board Certification , Geographic Practice, and Scholarly achievements.
Benchmark: TBD

[12] Family Medicine, Internal Medicine, and Pediatrics

BIBLIOGRAPHY

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Hernon, P. & Dugan, R.E. (2004). *Outcomes Assessment in Higher Education.* Libraries Unlimited: Westport, CT

APPENDICES

Proposal Time-Line for CFAM (Curriculum and Faculty Assessment Members) Plan					
Stage 1 →	Research Assessment Plan developed by MAYO clinic researched by Steering Comm.	Working committee presents modified proposal to Assessment sub-committee	Sub-committee approves proposal for new CFAM program	NYCOM Curriculum committee receives CFAM proposal and Training Video.	MAYO clinic student style assessment plan approved for Spring 1sr year class 2009 Pilot
Stage II →	March 1, 2009, First Year Pilot begins	Training Video first used March 2009 for Pilot	300 of 1st year students and 300 of 2nd year students assigned to evaluate one Course Aug. 2009	Goals of Mayo plan: 1-Improved assessment 2-Student Professionalism 3-Student empowerment	Time Line Created for plan for class of 2009 fall and 2010 Spring
Stage III →	Office of Assessment reports back to Curriculum committee June of 2009	Group Advisors selected June-July 2009 by Introd. Course Director	Kick-off of New Assessment Plan during Student Orientation Aug. 2009	Summer of 2009 Orientation for Assessment skills-Profession alism vinyl cards printed.	Group Advisors and Course Directors meet with Student group for assessment
Stage IV →	Student evaluators for each course take notes on faculty and lectures for one week.	All student evaluations reduced to one page summary in professional wording at the end of a Thread	Group Advisors assist students in properly writing the one page summary	A presentation is made to the Round Table at the end of the Course	Recommendation s are forwarded to the Curriculum Committee
Stage V →	Student Leaders of assessment group makes it's presentation to the NYCOM Curriculum Committee	Modifications if any are made by Curriculum Committee	Plan continues into spring 2010 semester	Plans for year 2, 3, and 4th yr. Professionalism and student assessment are made and sent to curriculum committee	Assessment of the New Asssessment Program

NEUROLOGICAL EXAMINATION

1	**Assess Cranial Nerve I - Olfactory** Examiner checks for patient's sense of smell by, e.g. coffee, soap, peppermint, orange peels, etc.	
2	**Assess Cranial Nerve II - Optic: Assessing Visual Fields by Confrontation** ▪ Examiner stands at approximate eye-level with patient, making eye contact. ▪ Patient is then asked to return examiner's gaze e.g. by *saying "Look at me."* ▪ Examiner starts by placing his / her hands outside the patient's field of vision, lateral to head. ▪ With fingers wiggling (so patient can easily see them) the examiner brings his / her fingers into the patient's field of vision.	    ▪ Examiner must ask the patient *"Tell me when you see my fingers."* ▪ Assess upper, middle and lower fields, bilaterally.

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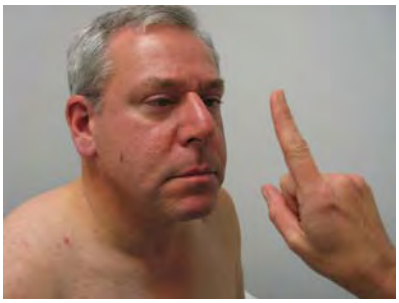
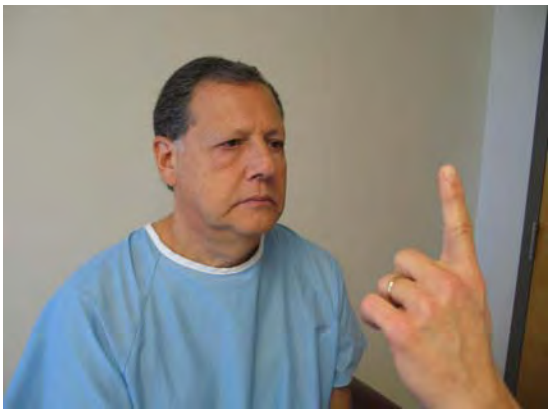
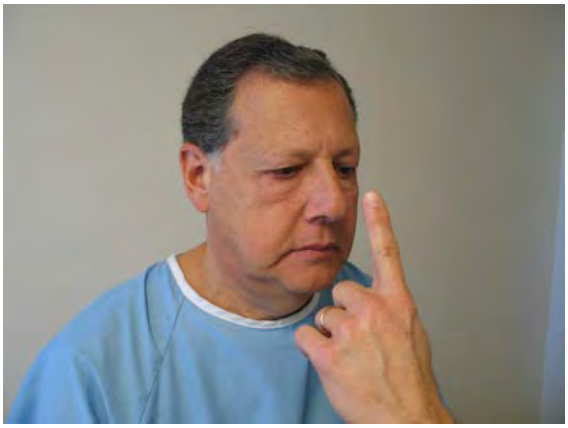
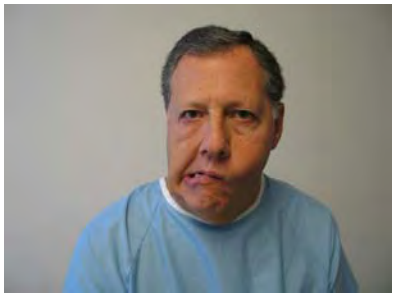
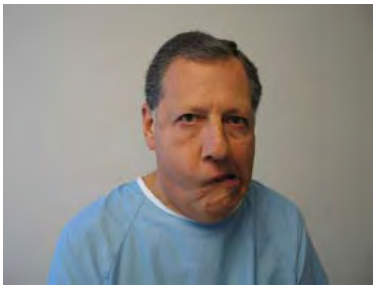
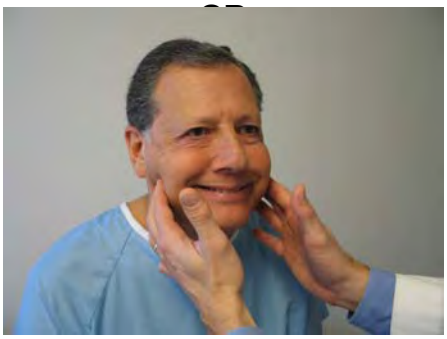
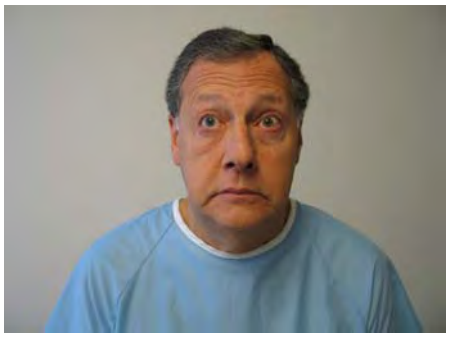
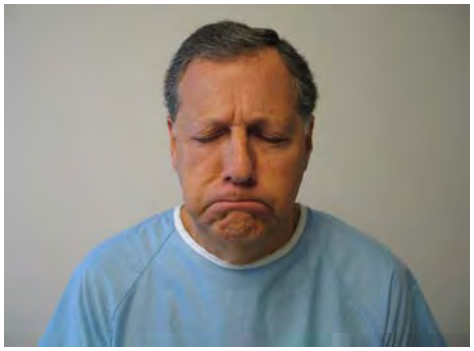
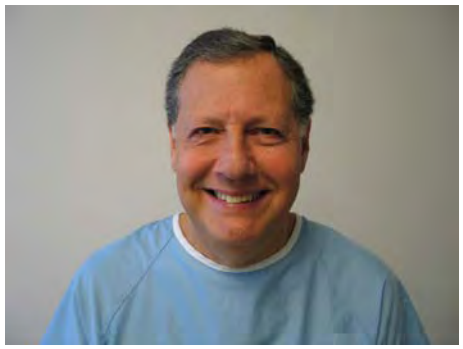
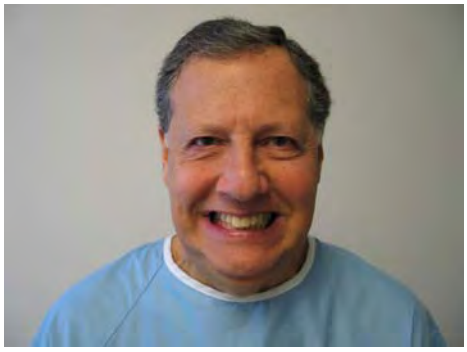
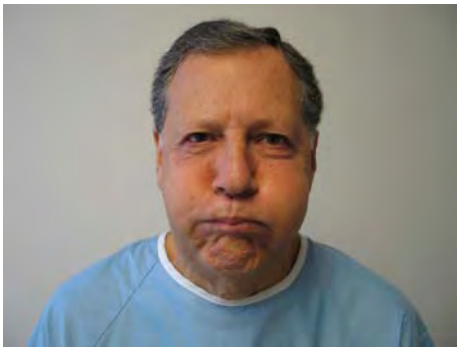
3	**Assess Cranial Nerve II – Optic: Accessing Visual Acuity** ▪ For ICC purposes, handheld *Rosenbaum Pocket Screener (eye chart)* ▪ NOTE: Use handheld *Snellen eye chart* if patient stand 20' from the chart ▪ Ask patient to cover one eye while testing the other eye ▪ Rosenbaum eye chart is held in good light approximately 14" from eye ▪ Determine the smallest line of print from which patient can read more than half the letters ▪ The patient's visual acuity score is recorded as two numbers, e.g. "20/30" where the top number is the distance the patient is from the chart and the bottom number is the distance the normal eye can read that line. ▪ Repeat with the other eye	

4	**Assessing Cranial Nerves II and III - Optic and Oculomotor: Assessing direct and Consensual Reactions** ▪ Examiner asks the patient to look into the distance, then shines a light obliquely into each pupil twice to check both the *direct reaction* (pupillary constriction in the same eye) and *consensual reaction* (pupillary constriction in the opposite eye). ▪ Must be assessed bilaterally.	 
5	**Assessing Cranial Nerves II and III - Optic and Oculomotor: Assessing Near Reaction and Near Response** ▪ Assessed in normal room light, testing one eye at a time. ▪ Examiner holds a finger, pencil, etc. about 10 cm. from the patient's eye. ▪ Asks the patient to look alternately at the finger or pencil and then into the distance. ▪ Note pupillary constriction with near focus.	 **Close focus**  **Distant focus**

6	**Assessing Cranial Nerve III** **- Oculomotor: Assessing Convergence** ▪ Examiner asks the patient to follow his / her finger or pencil as he / she moves it in toward the bridge of the nose to within about 5 to 8 centimeters. ▪ Converging eyes normally follow the object to within 5 – 8 cm. of the nose.	 
7	**Assessing Cranial Nerve III, IV and VI** **- Oculomotor, Trochlear And Abducens:** **Assessing Extra Ocular Muscle Movement** ▪ Examiner assesses muscle movements in at least 6 positions of gaze by tracing, for example, an "H pattern" with the hand and asking the patient to follow the hand with their eyes without turning the head.	

8	**Assessing Cranial Nerve V** **- Trigeminal (Sensory)** Examiner assesses sensation in 3 sites: ❖ Ophthalmic ❖ Maxillary ❖ Mandibular ▪ Examiner may use fingers, cotton, etc. for the assessment. ▪ Assess bilaterally.	**Ophthalmic** **Maxillary**    **Mandibular**
9	**Assessing Cranial Nerve V** - **Trigeminal (Motor)** ▪ Examiner asks the patient to move jaw his or her jaw from side to side OR ▪ Examiner palpates the masseter muscles and asks patient to clinch his / her teeth. ▪ Note strength of muscle contractions.	  OR 

10	**Assessing Cranial Nerve VII – Facial: Motor Testing** Examiner asks patient to perform ~~any 4~~ of the following 6 exams: ▪ Raise both eyebrows ▪ Close eyes tightly, then try to open against examiner's resistance ▪ Frown ▪ Smile ▪ Show upper and lower teeth ▪ Puff out cheeks Note any weakness or asymmetry.	 **Raise eyebrows**  **Opening eyes against resistance**  **Frown**  **Smile**  **Show teeth**  **Puff cheeks**

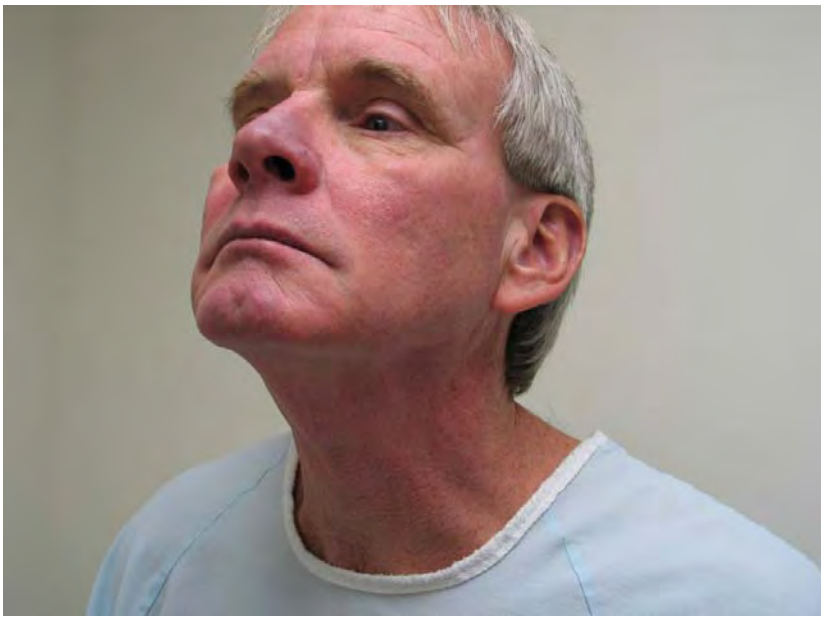
11	**Assess Cranial Nerve VIII – Acoustic** ***Weber test* – for lateralization** ▪ Use a 512 Hz or 1024 Hz turning fork. ▪ Examiner starts the fork vibrating e.g. by tapping it on the opposite hand, leg, etc. ▪ Base of the tuning fork placed firmly on top of the patient's head. ▪ Patient asked *"Where does the sound appear to be coming from?"* (normally it will be sensed in the midline).	

12	**Assessing Cranial Nerve VIII – Acoustic** ***Rinne test* – to compare air and bone conduction** ▪ Use a 512 Hz or 1024 Hz turning fork. ▪ Examiner starts the fork vibrating, e.g. by tapping it on the opposite hand, leg, etc. ▪ Base of fork placed against the mastoid bone behind the ear. ▪ Patient asked to say when he / she no longer hears the sound ▪ When sound no longer heard, examiner moves the tuning fork (without re-striking it) and holds it near the patient's ear and ask if he / she can hear the vibration. ▪ Examiner must vibrate the tuning fork again for the second ear. ▪ Bilateral exam. NOTE: (AC>BC): Air conduction greater than bone conduction.	 **Mastoid Bone**  **Ear**

13	**Assessing Cranial Nerve VIII -- Gross Auditory Acuity** ▪ Examiner asks patient to occlude (cover) one ear. ▪ Examiner then whispers words or numbers into non-occluded ear from approximately 2 feet away. ▪ Asks patient to repeat whispered words or numbers. ▪ Compare bilaterally. OR ▪ Examiner asks patient to occlude (cover) one ear. ▪ Examiner rubs thumb and forefinger together next to patient's non-occluded ear and asks the patient if the sound is heard. ▪ Compare bilaterally.	 

14 **Assessing Cranial Nerve IX and X – Glossopharyngeal and Vagus: Motor Testing**

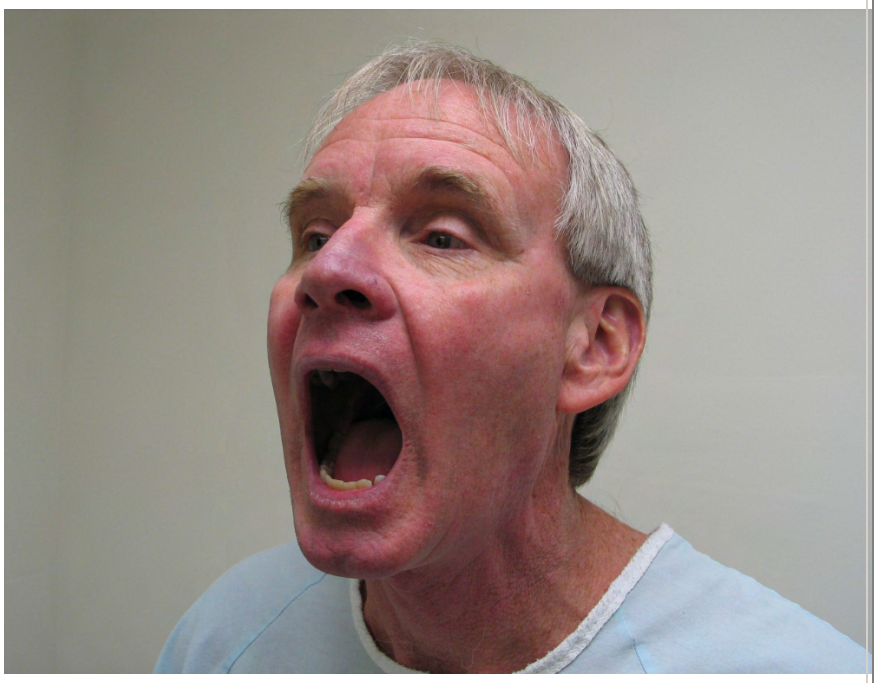
- First, examiner asks the patient to swallow.



Swallowing

- Next, patient asked to say *'aah'* and examiner observes for symmetrical movement of the soft palate or a deviation of the uvula.
- OPTIONAL: Use a light source to help visualize palate and uvula.

NOTE: sensory component of cranial nerves IX and X is testing for the "gag reflex"



Saying *"Aah"*

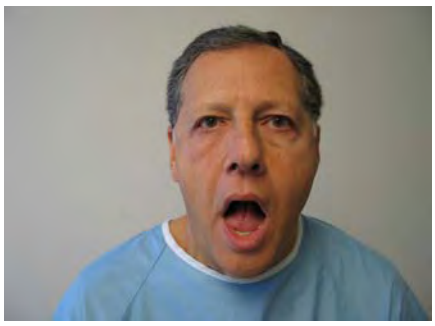
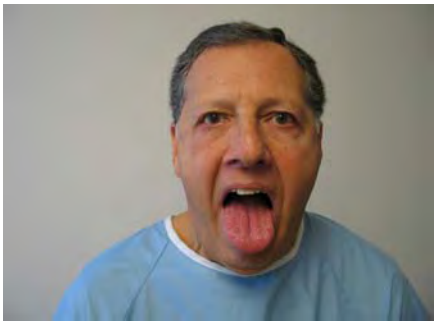
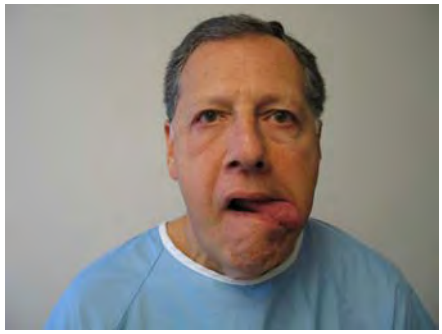
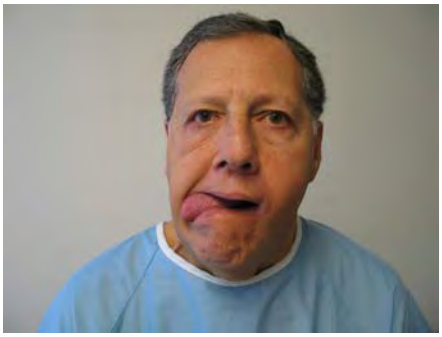
15

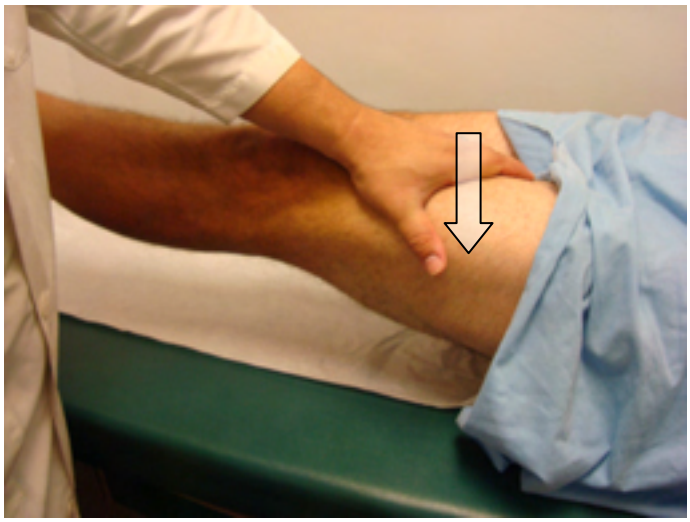
Assessing Cranial Nerve XI - Spinal Accessory: Motor Testing

- Examiner asks the patient to shrug his / her shoulders up against the examiner's hands. Apply resistance.
- Note strength and contraction of trapezius muscles.

- Next, patient asked to turn his or her head against examiner's hand. Apply resistance.
- Observe the contraction of the opposite sternocleido-mastoid muscle.

- Assess bilaterally.

16	**Assessing Cranial Nerve XII – Hypoglossal: Motor Testing** ▪ First, examiner inspects patient's tongue as it lies on the floor of the mouth. ▪ Note any asymmetry, atrophy or fasciculations. ▪ Next, patient asked to protrude the tongue. ▪ Note any asymmetry, atrophy or deviations from the midline. ▪ Finally, patient asked to move the tongue from side to side. ▪ Note any asymmetry of the movement.	  **Inspect tongue** **Protruding Tongue**   **Side to Side Movement**

17	**Assessing Lower Extremities – Motor Testing** With patient in supine position, test bilaterally ▪ Test *flexion* of the hip by placing your hand on patient's thigh, and ask them to raise his / her leg against resistance. ▪ Test *extension* of the hip by having patient push posterior thigh against your hand	 

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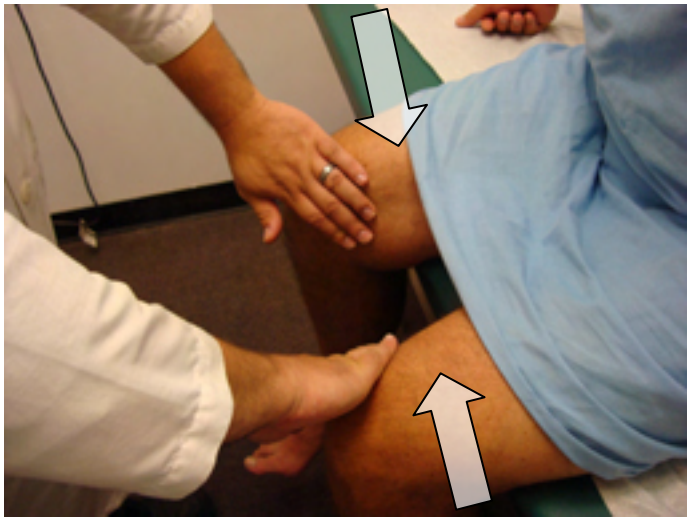
18	**Assessing Lower Extremities – Motor Testing** With patient in seated position, test bilaterally ▪ Test *adduction* of the hip by placing hands firmly between the knees, and asking them to bring the knees together ▪ Test *abduction* of the hip by placing hands firmly outside the knees, and asking patient to spread their legs against resistance	 

19	**Assessing Upper Extremities - Motor Testing** ▪ Examiner asks patient to pull (flex) and push (extend) the arms against the examiner's resistance. ▪ Bilateral exam. 	
20	**Assessing Lower Extremities – Motor Testing** ▪ Examiner asks the patient to pull (flex) and push (extend) the legs against the examiner's resistance. ▪ Bilateral exam. 	

21	**Assessing Lower Extremities – Motor Testing** ▪ Examiner asks patient to *dorsiflex* and *plantarflex* the ankle against resistance ▪ Compare bilaterally	 

22 **Assessing the Biceps Reflex**

- Examiner partially flexes patient's arm.
- Strike biceps tendon with reflex hammer (pointed or flat end) with enough force to elicit a reflex, but not so much to cause patient discomfort.

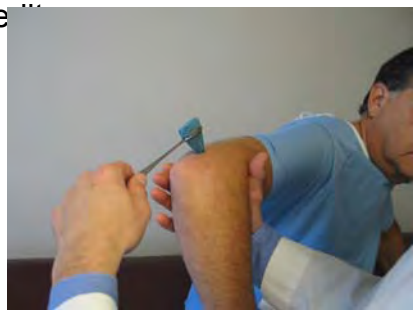
OPTIONAL: Examiner places the thumb or finger firmly on biceps tendon with the pointed end of reflex hammer only.

- Reflexes must be assessed bilaterally.
- Examiner must produce a reflex for credit.

OR

23 **Assessing the Triceps Reflex**

- Examiner flexes the patient's arm at the elbow, and then taps the triceps tendon with reflex hammer.
- Reflexes must be assessed bilaterally.
- Examiner must produce a reflex for credit.



24	**Assessing the Brachioradialis Reflex** ▪ With the patient's hand resting in a relaxed position, e.g. on a table, his / her lap or supported by examiner's arm, the examiner strikes the radius about 1 or 2 inches above the wrist with the reflex hammer. ▪ Reflexes must be assessed bilaterally. ▪ Examiner must produce a reflex for credit.	 

25 **Assessing the Patellar Tendon Reflex**

- First, patient asked to sit with their legs dangling off the exam table.
- Reflexes assessed by striking the patient's patellar tendon with a reflex hammer on skin.
- Reflexes must be assessed bilaterally.
- Examiner must produce a reflex for credit.

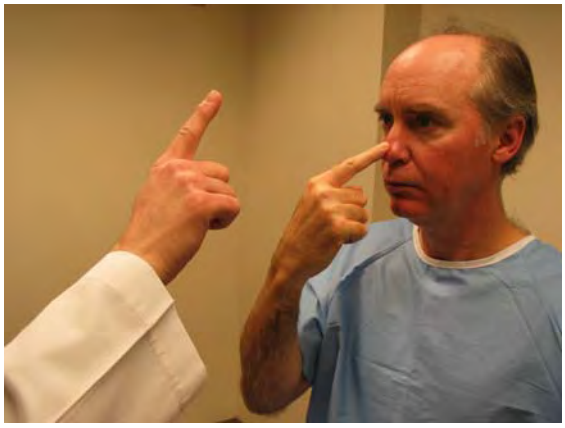
OPTIONS:
- Examiner can place his / her hand on the on patient's quadriceps, but this is optional.
- Patient's knees can be crossed.

25	**Assessing the Achilles Reflex** ▪ Examiner dorsiflexes the patient's foot at the ankle ▪ Achilles tendon struck with the reflex hammer on skin, socks completely off (removed at the direction of the examiner). ▪ Reflexes must be assessed bilaterally. ▪ Examiner must produce a reflex for credit.	 

26 **Assessing the Plantar, or *Babinski*, Response**

- Examiner strokes the lateral aspect of the sole from the heel to the ball of the foot, curving medially across the ball, with an object such as the end of a reflex hammer.
- On skin, socks completely off (removed at the direction of the examiner).
- Assessment must be done bilaterally
- Note movement of the toes (normally toes would curl downward).

27	**Assessing Rapid Alternating Movements** Examiner must do all three assessments for credit: ▪ Examiner directs the patient to pronate and supinate one hand rapidly on the other. ▪ Patient directed to touch his / her thumb rapidly to each finger on same hand, bilaterally. ▪ Patient directed to slap his / her thigh rapidly with the back side of the hand, and then with the palm side of the hand, bilaterally.	     

29	**Assessing Finger-to-Nose Movements** ▪ Examiner directs the patient to touch the examiner's finger with his or her finger, and then to place his or her finger on their nose. ▪ Examiner moves his / her finger randomly during multiple movements. 	

30

Assessing Gait

Examiner asks patient to perform the following:

Walk, turn and come back

- Note imbalance, postural asymmetry, type of gait (e.g. shuffling, walking on toes, etc.), swinging of the arms, and how patient negotiates turns.

Heel-to-toe (tandem walking)

- Note an ataxia not previously obvious

Shallow knee bend

- Note difficulties here suggest proximal weakness (extensors of hip), weakness of the quadriceps (the extensor of the knee), or both.

31	**Performing the *Romberg* Test** ▪ Examiner directs the patient to stand with feet together, eyes closed for *at least* 20 seconds without support. ▪ During this test, examiner must stand behind the patient to provide support in case the patient loses his / her balance.	
32	**Testing for Pronator Drift** ▪ Examiner directs the patient to stand with eyes closed, simultaneously extending both arms, with palms turned upward, for *at least* 20 seconds. ▪ During this test, examiner must stand behind the patient to provide support in case the patient loses his / her balance.	

NEUROLOGICAL EXAMINATION

SPECIAL TESTING

1	**Sensory Testing** ▪ First, examiner demonstrates what sharp vs. dull means by brushing the patient with a soft object, e.g. a cotton ball or smooth end of tongue depressor, and a semi-sharp object, e.g. broken end tongue depressor. ▪ Examiner performs this test on arms and legs bilaterally by randomly brushing the patient's arms and legs with the soft and semi-sharp objects, e.g. a cotton ball, semi-sharp object, etc.. ▪ Patient directed to keep his / her eyes closed during the examination as he or she identifies sharp vs. dull on skin. ▪ Bilateral exam, upper and lower extremities.	 

TASKFORCE MEMBERS

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Leonard Goldstein, DDS, PH.D.	Director, Clerkship Education
Abraham Jeger, Ph.D.	Associate Dean, Clinical Education
Rodika Zaika, M.S.	Director, Admissions
Ron Portanova, Ph.D.	Associate Dean, Academic Affairs